Arizona Medicine

Journal of

ARIZONA MEDICAL ASSOCIATION

VOL. 10, No. 7 • JULY, 1953 • TABLE OF CONTENTS — PAGE V

Meat and its applicability in the Dietary Management of Atherosclerosis

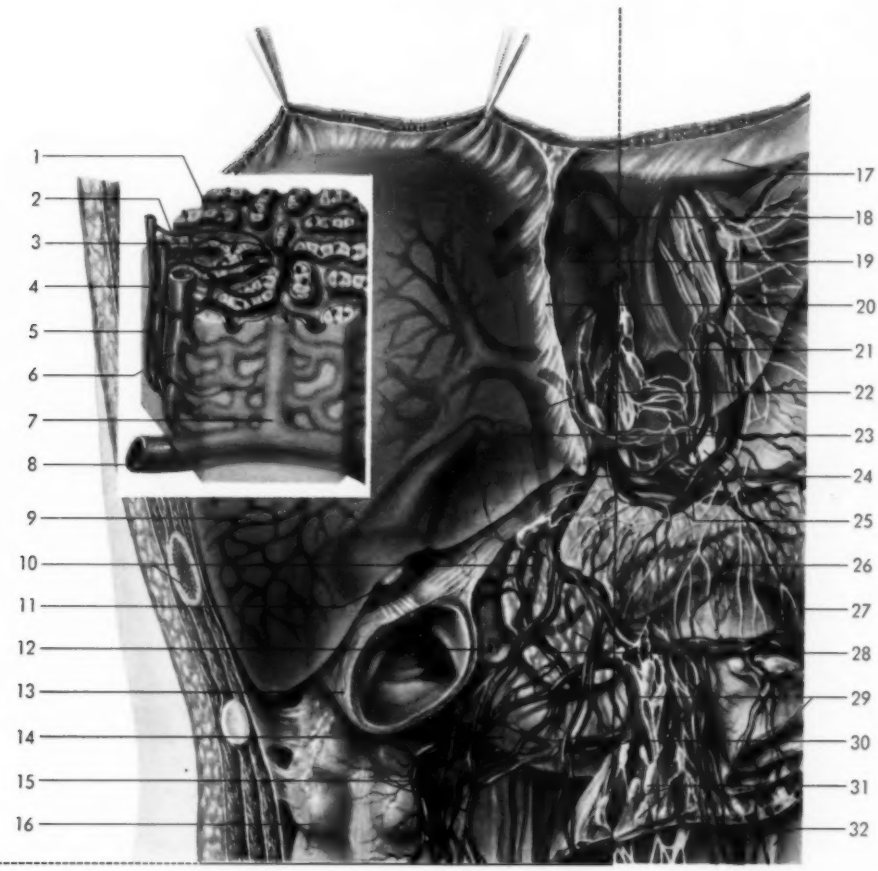
Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3, 5]

Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

1. Hildreth, E.A.; Hildreth, D.M., and Mellinkoff, S.M.: Principles of a Low Fat Diet, Circulation *4*:899 (Dec.) 1951.
2. Bloch, K.: The Intermediary Metabolism of Cholesterol, Circulation *1*:214 (Feb.) 1950.
3. Keys, A.; Mickelson, O.; Miller, E.V.O., and Chapman, L.B.: The Relation in Man Between Cholesterol Levels in the Diet and in the Blood, Science *112*:79, 1950.
4. Gubner, R., and Ungerleider, H.E.: Arteriosclerosis, a Statement of the Problem, Am. J. Med. *6*:60, 1949.
5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation *3*:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. *10*:1 (Jan.) 1952.

Upper Right Quadrant of the Abdomen



1 Sinusoid
2 Arteriole
3 Bile capillary
4 Branch of hepatic artery
5 Bile duct
6 Branch of portal vein
7 Central vein
8 Branch of inferior vena cava
9 Right lobe of liver
10 Common bile duct and tenth rib
11 Gallbladder
12 Papilla of Vater
13 Transverse colon
14 Duodenum
15 Branches of right colic artery and vein
16 Ascending colon
17 Coronary ligament and esophagus
18 Left hepatic vein and left vagus nerve
19 Inferior vena cava and right vagus nerve
20 Falciform ligament and branch of portal vein
21 Abdominal aorta and celiac plexus
22 Hepatic duct and hepatic artery
23 Cystic duct and celiac artery
24 Celiac ganglion and gastroduodenal artery and vein
25 Left gastric artery and coronary vein
26 Pancreatic duct
27 Right gastroepiploic artery and vein
28 Head of pancreas and pancreaticoduodenal artery and vein
29 Superior mesenteric artery and vein, and jejunum
30 Right colic artery and vein
31 Superior mesenteric lymph nodes
32 Inferior mesenteric vein and left ureter

This is one of a series of paintings for Lederle by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

ARIZONA MEDICINE

Journal of ARIZONA MEDICAL ASSOCIATION

VOL. 10, NO. 7 JULY, 1953

TABLE OF CONTENTS

Published monthly by the Arizona Medical Association. Business office at 424 Heard Building, Phoenix, Arizona. Subscription $3.00 a year, single copy 25c. Entered as second class matter March 1, 1921, at Postoffice at Phoenix, Arizona, Act of March 3, 1879.

Directory

THE ARIZONA MEDICAL ASSOCIATION, INC.
Organized 1892 — 541 SECURITY BUILDING
234 NORTH CENTRAL AVE., PHOENIX, ARIZONA

OFFICERS AND COUNCIL

Edward M. Hayden, M.D. ..... President
1603 N. Tucson Boulevard, Tucson, Arizona
Oscar W. Thoeny, M.D. ..... President-Elect
1313 N. 2nd Street, Phoenix, Arizona
Harry E. Thompson, M.D. ..... Vice-President
433 N. Tucson, Boulevard, Tucson, Arizona
Dermont W. Melick, M.D. ..... Secretary
15 East Monroe, Phoenix, Arizona
Clarence E. Yount, Jr., M.D. ..... Treasurer
P. O. Box 1626, Prescott, Arizona
Lindsay E. Beaton, M.D. ..... Speaker of House
1650 N. Campbell Ave., Tucson, Arizona
Jesse D. Hamer, M.D. ..... Delegate to AMA
15 East Monroe, Phoenix, Arizona
Robert E. Hastings, M.D. ..... Alternate-Delegate to AMA
1014 N. Country Club Road, Tucson, Arizona
R. Lee Foster, M.D. ..... Editor-In-Chief
15 East Monroe, Phoenix, Arizona

DISTRICT COUNCILORS

David C. James, M.D. ..... Central District
926 E. McDowell Rd., Phoenix, Arizona
Kent H. Thayer, M.D. ..... Central District
1313 N. 2nd Street, Phoenix, Arizona
Leslie B. Smith, M.D. ..... Central District
926 East McDowell Road, Phoenix, Arizona
Herbert B. Potthoff, M.D. ..... Northeastern District
P. O. Box 128, Holbrook, Arizona
Ernest A. Born, M.D. ..... Northwestern District
107 North Cortez, Prescott, Arizona
Guy B. Atonna, M.D. ..... Southeastern District
447 10th Street, Douglas, Arizona
Wilkins R. Manning, M.D. ..... Southern District
620 N. Country Club Road, Tucson, Arizona
Royal W. Rudolph, M.D. ..... Southern District
1627 N. Tucson, Boulevard, Tucson, Arizona
Abe I. Podolsky, M.D. ..... Southwestern District
1601 5th Avenue, Yuma, Arizona

COUNCILOR AT LARGE

Thomas H. Bate, M.D. ..... Past President
15 East Monroe, Phoenix, Arizona

BOARDS

PROFESSIONAL: Hugh C. Thompson, M. D., Tucson (Chairman); Ernest A. Born, M. D., Prescott; Edward H. Bregman, M. D., Phoenix; Orin J. Farness, M. D., Tucson; Lewis H. Howard, M. D., Tucson; Elvie B. Jolley, M. D., Bisbee; Joseph M. Kinkade, M. D., Tucson; Charles E. Van Epps, M. D., Phoenix; George A. Williamson, M. D., Phoenix.

PUBLIC RELATIONS: Leo J. Kent, M. D., Tucson (Chairman); Howard C. Lawrence, M. D., Phoenix (Vice Chairman); Lindsay E. Beaton, M. D., Tucson; Carlos C. Craig, M. D., Phoenix; Donald F. DeMarse, M. D., Holbrook; Wilkins R. Manning, M. D., Tucson; Robert M. Matts, M. D., Yuma; Zenas B. Noon M. D., Nogales.

STANDING COMMITTEES

GRIEVANCE: Thomas H. Bate, M. D., Phoenix (Chairman); Lindsay E. Beaton, M. D., Tucson; Preston T. Brown, M. D., Phoenix; Arthur C. Carlson, M. D., Phoenix; Robert E. Hastings M. D., Tucson; Hilary D. Ketcherside, M. D., Phoenix; Harry T. Southworth, M. D., Prescott.

HISTORY & OBITUARIES: W. Warner Watkins, M. D., Phoenix (Historian); R. Lee Foster, M. D., Phoenix; Dermont W. Melick, M. D., Phoenix; Hal W. Rice, M. D., Tucson.

INDUSTRIAL RELATIONS: John R. Schwartzmann, M. D., Tucson (Chairman); Carl H. Gans, M. D., Morenci; Ronald S. Haines, M. D., Phoenix; William B. McGrath, M. D., Phoenix; Zenas B. Noon, M. D., Nogales.

LEGISLATION: Reed D. Shupe, M. D., Phoenix (Chairman); Jesse D. Hamer, M. D., Phoenix (Vice Chairman); Carl W. Ahl, M. D., Douglas; William H. Bates, M. D., Cottonwood; Walter Brazie, M. D., Kingman; Ellis V. Browning, M. D., Springerville; Max Costin, M. D., Tucson; Donald F. Hill, M. D., Tucson; Bert E. Lambrecht, M. D., Miami; Stanton C. Lovre, M. D., Clifton; Wilkins R. Manning, M. D., Tucson; Robert M. Matts, M. D., Yuma; Zenas B. Noon, M. D., Nogales; Donald A. Polson, M. D., Phoenix; Wallace A. Reed, M. D., Phoenix; Leo Schnur, M. D., Grand Canyon; Leslie B. Smith, M. D., Phoenix; Noel G. Smith, M. D., Safford; Guss B. Steward, M. D., Coolidge; Kent H. Thayer, M. D., Phoenix; Harry E. Thompson, M. D., Tucson; Myron G. Wright, M. D., Winslow.

MEDICAL DEFENSE: Preston T. Brown, M. D., Phoenix (Chairman); Ernest A. Born, M. D., Prescott; Harold W. Kohl, M. D., Tucson.

MEDICAL ECONOMICS: Hilary D. Ketcherside, M. D., Phoenix (Chairman); Royal W. Rudolph, M. D., Tucson; Hugh C. Thompson, M. D., Tucson.

PUBLISHING: R. Lee Foster, M. D., Phoenix (Chairman); Carroll C. Creighton, M. D., Flagstaff; Donald E. Nelson, M. D., Safford; Darwin W. Neubauer, M. D., Tucson.

SCIENTIFIC ASSEMBLY: Oscar W. Thoeny, M. D., Phoenix (Chairman); Joseph Bank, M.D., Phoenix; David Engle, M.D., Tucson; Francis M. Findlay, M. D., Kingman; David C. James, M. D., Phoenix; Wilkins R. Manning, M. D., Tucson; Donald E. Nelson, M. D., Safford; William A. Phillips, M. D., Yuma; Herbert B. Potthoff, M. D., Holbrook.

Woman's Auxiliary

OFFICERS OF THE AUXILIARY TO THE ARIZONA MEDICAL ASSOCIATION — 1953 - 1954

President ..... Mrs. George S. Enfield
335 W. Cambridge Ave., Phoenix
President-Elect ..... Mrs. Brick P. Storts
3228 E. 5th Street, Tucson
1st Vice President (Organization) ..... Mrs. Roy Hewitt
130 Camino Miramonte, Tucson
2nd Vice President (Program) ..... Mrs. Charles S. Powell
698 Ninth Ave., Yuma
Treasurer ..... Mrs. R. Lee Foster
2215 N. 11th Ave., Phoenix
Recording Secretary ..... Mrs. Louis Hirsch
Rt. 6, Box 710, Tucson
Corresponding Secretary ..... Mrs. William F. Schoffman
36 N. Country Club Dr., Phoenix
Director (1 year) ..... Mrs. T. C. Harper
175 S. Third Street, Globe
Director (1 year) ..... Mrs. William F. Schoffman
36 N. Country Club Dr., Phoenix
Director (2 year) ..... Mrs. Frederick W. Knight
Safford

STATE COMMITTEE CHAIRMEN 1953-1954

Bulletin ..... Mrs. Hiram Cochran
2716 E. 4th Street, Tucson
Chaplin ..... Mrs. James R. Moore
305 W. Granada, Phoenix
Civil Defense ..... Mrs. Frank A. Shallenberger
345 S. Eastbourne Dr., Tucson
Convention ..... Mrs. A. E. Cruthirds
60 E. Country Club Drive, Phoenix
Finance ..... Mrs. Paul S. Causey
38 W. Camelback Road, Phoenix
Historian ..... Mrs. Benjamin Herzberg
125 W. Rose Lane, Phoenix
Legislation ..... Mrs. C. L. Von Pohle
274 N. Arizona Ave., Chandler
Medical Education Fd. ..... Mrs. J. B. Tucker
Box 1042, Casa Grande
Nurse Recruitment ..... Mrs. Max Costin
2648 E. 4th Street, Tucson
Parliamentarian ..... Mrs. Royal W. Rudolph
3935 Miner, Tucson
Publicity ..... Mrs. Ashton B. Taylor
46 E. Marlette Dr., Phoenix
Public Relations ..... Mrs. John K. Bennett
2325 E. Waverly St., Tucson
Revisions ..... Mrs. Jesse D. Hamer
1819 N. 11th Ave., Phoenix
Student Nurse Loan Fund ..... Mrs. Donald A. Polson
2163 W. Earll Dr., Phoenix
Todays Health ..... Mrs. James C. Soderstrom
Box 82, Whipple
Nominating Com. Chairman ..... Mrs. Royal W. Rudolph
3935 Miner, Tucson

COUNTY PRESIDENTS AND OFFICERS 1953-1954

GILA COUNTY

President ..... Mrs. Ira E. Harris
Box 1296, Miami
Vice President ..... Mrs. Charles T. Collopy
Box 623, Miami
Secretary-Treasurer ..... Mrs. William E. Bishop
605 S. 3rd St., Globe

MARICOPA COUNTY

President ..... Mrs. Paul B. Jarrett
501 E. Pasadena, Phoenix
President-Elect ..... Mrs. Robert H. Cummings
5830 Arcadia Lane, Phoenix
1st Vice President ..... Mrs. C. Selby Mills
5821 N. 11th, Phoenix
2nd Vice President ..... Mrs. George A. Williamson
537 W. Rose Lane, Phoenix
Rec. Secretary ..... Mrs. Robert A. Price
335 W. Windsor Ave., Phoenix
Cor. Secretary ..... Mrs. Samuel H. Hale
Rt. 1, Box 382, Scottsdale
Treasurer ..... Mrs. Dwight H. Porter
5650 N. 12th, Phoenix

GRAHAM COUNTY

President ..... Mrs. Noel Grey Smith
Safford
Vice-Pres. ..... Mrs. Robert Keller
Safford
Sec.-Treas. ..... **Mrs. Donald E. Nelson**
Safford

PIMA COUNTY

President ..... Mrs. Hugh C. Thompson
135 Palomar Dr., Tucson
President-Elect ..... Mrs. Joseph M. Kinkade
335 S. Country Club Rd., Tucson
1st Vice President ..... Mrs. Seymour I. Shapiro
2410 E. Elm St., Tucson
2nd Vice President ..... Mrs. George A. Shetter
2733 E. Mable St., Tucson
Rec. Secretary ..... Mrs. John K. Bennett
2325 E. Waverly St., Tucson
Cor. Secretary ..... Mrs. D. E. Engle
4012 E. Cooper, Tucson
Treasurer ..... Mrs. Richard K. Hausmann
2639 E. 8th St., Tucson

PINAL COUNTY

President ..... Mrs. Howard Holmes
Eloy
Vice President ..... Mrs. James T. O'Neil
Casa Grande
Sec-Treasurer ..... Mrs. Robert Z. Collings
Box 475, Casa Grande

YAVAPAI COUNTY

President ..... Mrs. Melvin W. Phillips
829 Flora Ave., Prescott
Vice President ..... Mrs. Earnest Geever
Whipple
Sec-Treasurer ..... Mrs. William A. Marlowe
Whipple

YUMA COUNTY

President ..... Mrs. Phillip G. Corliss
Somerton, Box 68
Vice President ..... Mrs. John J. Kloby
Ave. C, Yuma
Sec-Treasurer ..... Mrs. Robert M. Matts
Yuma


resist

ARIZONA MEDICINE
Journal of Arizona Medical Association

VOL. 10, NO. 7 JULY, 1953

Original ARTICLES

LARGE SPONTANEOUS GASTROCOLIC FISTULA DUE TO CARCINOMA OF TRANSVERSE COLON CASE REPORT

HENRY P. LIMBACHER, M.D., F.A.C.S.
Tucson, Arizona

A sixty-seven year old white retired, electrical lineman was first seen December 14, 1951, as an emergency because of sudden massive hematemesis. When first seen he had marked air hunger, precordial pain referred down his left arm, weak pulse and cold, clammy skin.

Approximately five months previously he had become very constipated for about one month, followed by a severe refractive diarrhea. He had lost about thirty pounds in weight. During the past month he had some epigastric pain relieved slightly by food, with almost daily emesis occasionally "coffee ground" and sometimes contained bright blood. He had had almost continuous emesis of blood for the past four hours.

His past history revealed nothing, he having always been unusually healthy and never having been hospitalized. He had a brother who died of cancer of unknown origin at the age of sixty-five.

Physical examination showed a well developed man with obvious weight loss, a scaphoid abdomen with a large, moderately tender mass in mid-epigastrium which was movable. There was no "rectal shelf" nor supraclavicular "sentinel node." The liver was not palpably enlarged. Blood pressure varied from 84/50 to 104/56; R. B. C. 2,800,000; Hemoglobin 5.8 gms.; marked microcytosis and hypochromia. Urine was negative.

Hospital Course: He was given 1500 cc. whole blood during the night and early morning, following which his blood pressure rose to 120/64 and he insisted on sitting on the edge of the bed. He was maintained on 5% glucose in saline and water and Alcohol Trinidex® Cephalin Flocculation was 1 plus in twenty-four hours, 3 plus in forty-eight hours.

On the third hospital day an upper gastro-intestinal series showed a diverticulum of the greater curvature of the stomach, which measured 5 cm. x 8.5 cm., which communicated with the transverse colon. Duodenum filled normally.

Barium enema was performed the next day. As the barium reached the distal one-fourth of the transverse colon it promptly filled the large sac described above, as well as the stomach and duodenum. There was marked filling of the small bowel from beginning to end. The proximal colon filled only slightly. (Fig. A).

There was no evidence of further bleeding and the patient was placed on a two day preparation for surgery: Terramycin 250 mgms. every four hours with high caloric low residue diet and enemas twice daily containing 5 gms. powdered sulfathaladine in each enema. A Levine tube with continuous suction was placed in the stomach the night before surgery.

At surgery the abodmen was opened through a midline incision from xyphoid to umbilicus. The omentum was found to be densely adherent to the mass. There were practically no adhesions to the small bowel nor to the pancreas. There was no obvious celiac or para-aortic nodal involvement. Liver and pelvis were clear. Two-thirds of the stomach and transverse colon were excised enmasse. The stomach was approximated

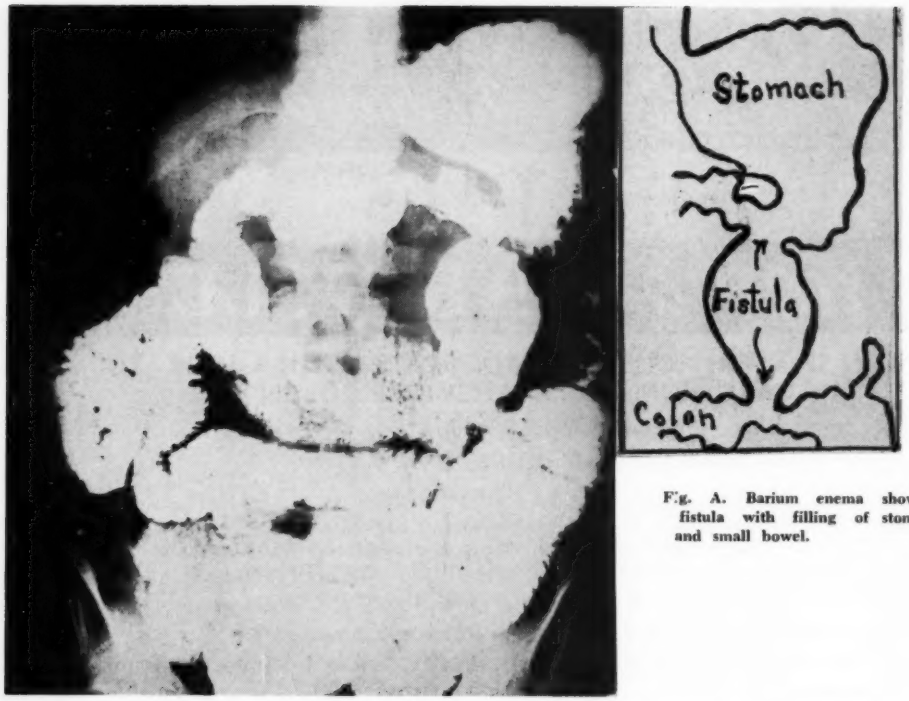


Fig. A. Barium enema showing fistula with filling of stomach and small bowel.

to duodenum by open anastomosis of Bilroth I type and end to end open anastomosis was made to unite proximal and distal colon. The patient received 1000 cc. whole blood in surgery, which required three hours. He was returned to the room with continuous Wangensteen suction. He was given Crystalline Penicillin 600,000 units, Streptomycin 0.5 gm. intramuscularly, and Terramycin 500 mgms. intravenously every twelve hours. He was given water, one to two ounces as desired immediately postoperatively with Wangensteen open.

He was out of bed on the second postoperative day and had a negative fluid balance with Levine tube clamped off one hour every three hours. He was given mineral oil, one ounce three times daily beginning the second day. The Levine tube was removed on the fourth postoperative day, the patient had three soft bowel movements and tolerated a full liquid diet. Because he had a marked aversion for hospitalization he was discharged on the fifth postoperative day. His preoperative temperature averaged 97.8° and postoperatively his maximum temperature was 98.2°, pulse 80. R.B.C. on second postoperative day was 4,480,000, Hemoglobin 13.5 gms.

Pathology Report: The specimen consisted of a section of stomach 20 cm. in length and a section of large intestine 20 cm. in length connected by a large fistula with a bulbous central portion with walls of necrotic anaplastic tissue measuring 1 cm. to 2.5 cm. in thickness. Microscopically the lesion was a markedly anaplastic adenocarcinoma. There was considerable mucinous degeneration with clusters of cancer cells embedded in mucous. These were occasionally of the signet ring type on the gastrict side. On the colon side the malignancy was more typical of that seen in colon cancer.

The patient increased his diet at home and returned to the office the tenth day for removal of the sutures. The wound was clear. He was last seen May 8, 1953, 18 months post surgery, at which time there was no evidence of recurrence, and he had gained from 124 lbs. immediately postoperatively to 166 pounds.

Comment: It was concluded at the time of surgery, because of the anaplastic character of the lesion and its wide extension, that the probability of cure was not good and that extensive resection, i.e., wider resection of the colon, total gastric resection and splenectomy with radical excision of celiac and para-aortic nodes, would greatly increase the morbidity without appreciably increasing chances for cure. As recently reported, it is the contamination of the proximal

small bowel by the return of feces into the stomach and back to the intestine that causes sepsis and rapid debilitation in gastrocolic fistulae. This fact was utilized in preparing this patient with enemas of sulfathaladine, together with oral and intravenous Terramycin, which contributed to the aseptic postoperative course.

Summary and Conclusions: An unusual case of neoplastic gastrocolic fistula is presented, which was admitted following severe hemorrhage, responded well to excision of stomach and transverse colon enmasse and was discharged on the eleventh hospital or fifth postoperative day. With use of antibiotics and careful clinical evaluation an extensive resection was performed with a minimum of laboratory procedures and hospitalization.

The writer wishes to acknowledge the services of Herbert D. Welsh, M.D. for preparation of the x-ray photographs.

EVALUATION OF MODERN DRUG THERAPY

L. MAXWELL LOCKIE, M.D.
Buffalo, New York

Tremendous strides have been made in the field of therapeutics during the past twenty years. Inasmuch as therapy is an important part of every physician's practice, it is with great interest that one looks over the recent past evaluate the various drugs which have been advocated and to determine their effectiveness. From the patient's point of view, therapy is the thing that counts.

In the present day, the trend is strong toward the use of single drugs. Thus, it is easy to determine if that drug is effective. This is more difficult when mixtures are prescribed. The metric system is the official measure in the United States. It is written more and more due to its ease of use. If abbreviations are written, to avoid mistakes, a physician must remember there are official abreviations for each drug and chemical substance. Also, medication in a solid form is preferred over liquids as the dosage is more accurate.

Twelve and one-half per cent of the total prescriptions filled by pharmacists in Buffalo, New York, are for antibiotics. Twenty per cent of these are for local use. In addition, three and two-tenths per cent of total prescriptions are written for sulfonamides. It would be logical to consider this group first.

Antibiotics

The mode of action of different antibiotics varies, as streptomycin and penicillin will kill organisms, while those of the A-C-T (Aureomycin, Chloromycetin and Terramycin) group merely inhibit their growth. Some antibiotics act on non-pathogenic organisms, but are ineffective against pathogens, while others are effective in vitro and not in vivo. The clinical value of some very potent preparations is limited by their extreme toxicity. To be effective, enough concentration of the antibiotic must be established where the infection exists. The toxicity of the antibiotic is dependent, to a certain extent, on dosage (except penicillin) and to sensitivity.

Absorption from intramuscular injection may be decreased in the following ways:

1. Suspension of crystals in a slowly absorped vehicle.
2. Relatively insoluble forms of the drug, such as procaine penicillin.
3. Large particles.
4. To coat them with water-repellent substances, such as aluminum monostearate gels.

The following antibiotics are those commonly in use today and their principal indications listed.

Penicillin. Streptococcus infections, Staphylococcus infections, Pneumococcal infections, Gonorrheal infections, Spirochetal infections, Prophylaxis — ophthalmia neonatorum, Prophylaxis — recurrence of rheumatic fever, Clostridial infections, especially peritonitis and gas gangrene, Diphtheria combined with antitoxin, Some respiratory infections.

Streptomycin. Tuberculosis with PAS, Tularemia, Brucellosis with A-C-T, Influenza bacillus, Friedlander's pneumonia.

Aureomycin, Chloromycetin, Terramycin. This relatively new group of antibiotics has a broader spectrum than penicillin alone. Occasionally a patient responds better to one of the group, but the evidence as of today indicates generally that one is just about as effective as the others, except against typhoid infection where chloromycetin is preferred. Gram-negative and gram-positive infections, Rickettsial infections, Virus pneumonia, Typhoid (chloromycetin preferred), Bru-

*Professor of Therapeutics, Medical School, Univ. of Buffalo.

cellosis with streptomycin, Water solution for impetigo.

Bacitracin. Rarely produces sensitivity when absorbed from the gastro-intestinal tract. Is very effective in local infections. May be used systemically in some penicillin or A-C-T resistant infections of severe grade.

Tyrothricin: Useful in local infections of respiratory tract and skin.

Gantrisin: Especially useful in some urinary tract infections.

Polymyxin: Pyocyanus infections respond very well, especially meningitis and ear.

Sulfadiazine: Still the most commonly used form of sulfonamide. There is little difference in price of various kinds. It has minimal reactions and a relatively broad spectrum. A mixture of sulfonamides makes it possible to give more without crystalization in the urine. The principal uses are as follows: Gram-negative and gram-positive infections, Upper respiratory infections in children, Chancroid. Epidemic meningitis, Prophylaxis–rheumatic fever, Urinary infections, Bacillary dysentery.

Cortisone and ACTH

Since September, 1948, cortisone has occupied a spectacular place in affording relief of symptoms of rheumatoid arthritis. Since then, other uses have become known. Cortisone is a chemical which is one of the products of the adrenal gland of the body. It is made synthetically so that large amounts are available now. ACTH is an extract made from the pituitary glands of animals. This stimulates production of hormones, including cortisone, from the cortex of the adrenal gland. Thus, if a person does not have an adrenal gland cortex, ACTH is not effective. For the most part, ACTH and cortisone produce comparable results.

There are constant improvements in the manufacture of ACTH so that the dosage now of pure products is much smaller than that of the original ACTH. In fact, in one of the newer preparations, 2 mg. a day is able to do as much as 80 mg. of the original. Important side effects to watch for are Cushing's syndrome, fluid retention, gastro-intestinal and cardiac accidents, elevation of blood sugar, mental stimulation and withdrawal symptoms. All of these are quickly reversible except the mental symptoms which may take a long time. Important uses are as follows:

To relieve symptoms and signs of rheumatoid arthritis, Idiopathic stearrhea, Status asthmaticus, Serum sickness, Acquired hemolytic anemia. Inflammatory eye conditions, to prolong life in lupus erythematosis, Chronic non-specific ulcerative colitis.

Hydrocortone: Recently this has become available for use by local injection into painful joints of rheumatoid arthritis or osteoarthritis. A few patients have been reported to whom it has been given orally. The effects are comparable to cortisone, but the side effects are much less. Hydrocortone, when injected into the joint, will stay there seven times as long as cortisone.

Gastro-Intestinal Drugs

Banthine: A preparation which is found to be very effective in treating the symptoms of peptic ulcer. It is a true anticholinergic drug and gives consistent reduction of hypermotility and usually a reduction of hyperacidity. Most authors feel that after symptoms are relieved, a maintenance dose is necessary to prevent recurrences. Also, it has been found to be very effective in stopping excessive perspiration. Even a 50 mg. tablet may give marked relief for a long period of time.

Calcium carbonate: In the opinion of many, this old-time drug maintains its superiority as an antacid in the face of many other products.

Anion-Exchange Resins: When used orally in the treatment of peptic ulcer, the X-ray disappearance time of the ulcer crater will be about 45 per cent less compared to other forms of therapy. Apparently, it binds hydrochloric acid and inhibits activity of pepsin. It is effective.

Belladonna: Probably the most widely used medication to relieve gastric spasm.

Laxatives and Cathartics

There is little change in these preparations over the years except for a few of the bulk-producing forms.

Cascara: Acts on the large intestine.

Castor Oil: Acts on the small intestine.

Phenolphthalein: Acts by stimulating the colon.

Bulk-forming Preparations: Gives psychological help to many. However, a well-established habit time, once a day and no other time, usually is just as effective.

Sedatives and Hypnotics

Over the years, bromides and chloral have proved to be effective sedatives and are the drugs of choice of many of the older physicians.

Barbiturates: These are most popular. The one to use is determined by the time action desired. Long-acting – barbital and phenobarbital, Mod-

erately – nembutal and amytal, Short acting – seconal, Ultra-short – evipal and pentathol sodium.

Pain-Relieving Drugs

Morphine: Still remains the most popular drug used for the relief of pain. If a person is sensitive to it, pantapon may be substituted. The action of morphine occurs in the pain centers of the optic thalamus.

Codeine: Will help to relieve pain, especially when combined with salicylates. However, the constipating effect and mental depression frequently outweigh any prolonged benefit as an analgesic. The principal use is in the control of cough where it has a highly selective depressive action on the cough center. In this case, a liquid preparation of codeine sulfate or phosphate taken every hour or so is more beneficial for the relief of cough than any other single substance.

Demerol: Is a relatively recent analegsic which is very useful in the relief of pain. It is given best intramuscularly. There are side effects such as dizziness and sweating, which may interfere with its usefulness. It does not constipate or depress nor is it as habit-forming as morphine.

Methadon: Has been developed to take the place of morphine. Although it is not a closely related chemical, it does have the same pharmacological actions. Used for relief of pain over long periods of time and offers help in treatment of morphine addiction.

Etamon: Helps to control pain and swelling in chronic venous insufficiency. 200-500 mg. intravenously once or twice a week.

Depotestosterone: Painful breast metastases requiring only one injection daily.

Testosterone, Proprionate: For advanced breast cancer, particularly when metastases into the bone have occurred.

Magnesium, Carbonate: To relieve pain in Paget's disease. This is given several times a day, stirred in a small amount of water.

Vitamins

Vitamin A: Is found in almost all foodstuffs. However, where such a deficient diet has been used, there will be xerophthalmia and hyperkeratosis of the mucous membranes of the mouth and esophagus.

Vitamin B Complex: Has been one of the most effective drugs to increase the financial status of pharmaceutical houses as well as the middle man and retailer. It probably is of use in some cases organically, but its greatest use, I am sure, is the psychological effect. Many patients say they feel better while taking it as a general tonic. It is the only medication which is of value in neuritis. Intravenously, it has been useful in the relief of burning and tingling in the feet.

Nicotinic Acid: Necessary to prevent pellagra.

Vitamin B_{12}: Apparently is the potent substance of liver in the treatment of pernicious anemia. It will do everything that crude liver extract or refined liver extract will do for these patients. In order to be most effective, it should be given parenterally.

Vitamin C: Is also a much discussed vitamin. It must be taken at fairly regular intervals in order to prevent scurvy. As far as we know, Vitamin C is not stored in the body.

Vitamin D: Is a must in the diet of children up to the age of two so that rickets will not occur. Its use in the treatment of rheumaoid arthritis has long since been discarded.

Allergy Drugs

Benedryl, Pyribenzamine, Trimeton, Theopherin: Represent four different types of antihistaminic substances. If one is not effective in the treatment of allergic states, another can be tried. Serum sickness, hay fever, rose fever, and asthma are usually well-controlled, temporarily, by one of them. Protein shock which follows the administration of drugs can usually be avoided when one of these substances is given before. In blood transfusion, a small amount may be given with the blood to prevent reactions.

Cardio-Vascular Drugs

In this field, there are thousands of preparations which have come and gone, and even today authorities cannot agree on which are the best.

Digitalis: Probably the best heart medication is the powdered leaf of digitalis. The discovery of its use at the end of the 18th century was undoubtedly one of the greatest advances in medicine. In this case, it is advisable that a physician remember to use the product of one manufacturer as potencies are apt to vary, although the U.S.P. sets definite tests for standardization. Greatest use is in control of heart failure or impending heart failure, as well as in some cardiac irregularities.

Cation-Exchange Resin: Of carboxylic type. Withdraws sodium ions from the intestinal contents and thus limits the formation of edema. In the acid of the stomach, it releases K ions and binds H ions. In alkaline medium of intestines H ions are released, cations attracted, bound and

then carried out. There are potassium ions included in some preparations to compensate for those which may be removed from gastrointestinal tract to guard against K depletion.

Hexamethonium: Is one of the best preparations to use in the treatment of hypertensive emergencies. It is given in two doses daily over a long period of time. Although it may tend to produce symptoms of shock and hypotension, these effects can be easily controlled by having the patient elevate the feet for a few minutes. For a hypertensive crisis, the action is extremely prompt.

Hydergine: Is a new preparation containing hydrogenated ergotoxine alkaloids. It has central and peripheral actions producing vasodilatation, lowering the blood pressure and slowing the heart. Adrenergic blockade occurs. Useful in the treatment of peripheral vascular diseases and an adjunct in treatment of hypertension along with other measures. May be given hypodermically several times a week.

Paveril Phosphate: Works well where papaverine is indicated. There are particularly good effects in some patients with angina.

Sodium Heparin: Recently an investigator has found that 100 mg. weekly reduced markedly the number of attacks of angina pectoris.

Tetraethylammonium Chloride: Is of great value in evaluating the true hypertensive state, especially before surgery.

Nitrites: Are still the main stand-bys for the relief of muscular spasm of the coronary arteries, gall bladder, urinary tract and bronchial tree. It relaxes smooth muscles directly.

Isotopic Drugs

Iodine 131: Is an isotope of iodine which has a half life of eight days. It is very useful in the treatment of some patients with hyperthyroidism. Usually 2 mc. are given daily for an average-sized gland. About 15-20 per cent of thyroid cancers will absorb Iodine 131. Some of the patient's have been at death's door when this was given. This has stopped the progress of the disease, melted away metastases and enabled patients to live longer. It is too early to say a cure has been effected.

Phosphorus 32: Is one of the most widely used therapeutic isotopes. It is the drug of choice in the treatment of polycythemia vera. Also, very recently, it has been found the P-32 is picked up by epithelial and neural tumors. Found to be useful in the differential diagnosis of malignant tumors of the eye versus detachment of the retina. Geiger counter is placed over the eye to see if unusually large amounts are accumulating there. If so, that would indicate the presence of a malignant growth.

Gold 198: Is also beginning to be used widely. It has a half life of 2.7 days. It may be injected directly into a large cancerous mass or sewed in nylon thread impregnated with it. These sutures can be taken out at any time if necessary. Another use is that to inject into the peritoneal or thoracic cavity where a large amount of fluid is present due to malignant growths. It will retard the formation of the fluid.

Miscellaneous

Benzedrine and Dexedrine: Are useful to combat depression and narcolepsy. Given before breakfast and lunch, they diminish the appetite. If taken late in the day, they may produce insomnia.

Dicumerol: Use prophylactically in major surgical procedures to prolong bleeding time. No pulmonary emboli in 700 cases in a recent series. Also, routinely used by many in treatment of coronary thrombosis.

Heparin: Should be used when immediate rise in bleeding and clotting time is desired. It is valuable in that first 72-hour period before Dicumerol effect is obtained.

BAL: Is of special interest inasmuch as it usually controls readily any toxic manifestations following the use of gold, which is so widely given in the treatment of rheumatoid arthritis. The insoluble forms of gold are not controlled as easily as myochrysine or solganol. It is also of use in the treatment of chronic arsenic poisoning and mercurial poisoning. In mercury poisoning, if used within an hour, prevent nephrosis. Much less effective after six hours.

Cupric sulfate: Powdered form applied full strength directly to a canker sore will relieve it promptly.

Dramamine: Is of great value in a high percentage of people in the prevention of motion sickness. Usually 50 mg. orally or 100 mg. rectally given one hour before the trip is to start will be sufficient for the day. Moreover, it may be repeated in 4-6 hours.

Ergotamine: Is useful in migrane. Decreases pulsations of cerebral vessels and the tug on the meninges is relieved.

Quinine sulfate: Has been found to be of

great value in the treatment of night cramps of the legs.

Thiouracil: These preparations have decreased the hyperactivity of the thyroid gland in many patients. Usually it can be given over long periods of time with few toxic reactions.

Urecholine: Is of benefit when retention of urine occurs in absence of urinary obstruction.

Benemid: A new drug which is capable of reducing the level of uric acid in the blood by 30 per cent. It is especially useful in the treatment of patients with gout and gouty arthritis, although it does not cure an acute attack of gouty arthritis, nor will it prevent its appearance. However, it appears that the daily administration will lessen the number of attacks. In some patients observed over long periods of time, tophi have disappeared. The usual dose is a half gram twice daily. There are very few reactions to it when given in this amount, although bladder symptoms may occur in a few patients.

Colchicine: Is the oldest known drug of which we have knowledge. It was written in the Ebers Papyrus, 1550 B.C. It is one of 58 chemical agents with mitogenic effect. The use of colchicine is limited almost exclusively to the treatment and prevention of gouty arthritis. When a patient has an acute attack of gouty arthritis, he should be given a dose of ½ mg. every hour until nausea or a loose bowel movement occurs. Then it must be stopped. Between attacks, it is wise to give ½ mg. twice daily as a prophylactic dose. This can be increased quickly if an acute attack occurs.

Estrogens: There are many types of estrogen therapy available. Some patients react well to one and others to another form. If a woman has menopausal symptoms which require consultation with a physician, an estrogen should be given to relieve these symptoms. However, it should be used cautiously in the premenopausal patient.

Salicylates: In the form of acetylsalicylic acid or sodium salicylate act in the thalmus and in the kidney tubules. They are the most widely used drugs for relief of pain. When given in large amounts, usually relieve symptoms entirely of rheumatic fever. Valuable therapentic test.

Cinchophen: Increases uric acid excretion due to direct action on tubules of kidney. Reports of atrophy of the liver were recorded as seven cases per year up to 1936 and one case per year since. That means one case in approximately 10,000,000 doses.

Chloroquin: Useful in liver amebiasis. Malaria. 1 gm. at once; 0.5 gm. in 6 hours; 0.5 gm. the next two days.

Prostigmin: Useful in myasthenia gravis. Dosage depends on needs.

Folic Acid: Is found in all tissues. Transforms megaloblasts into mature RBC's. Useful in sprue, topical macrocytic anemia and anemia of pregnancy.

Nitrogen Mustard & Tri-ethyl-malamine: Useful in Hodgkins Disease. Tri-ethyl-malamine has the advantage that it can be taken orally.

Thus in the armamentarium of the physician, he must use some of the old and some of the new forms of medication in the treatment of disease.

PHOENIX *Clinical* CLUB

MASSACHUSETTS GENERAL HOSPITAL CASE NO. 17351

The Case History in this discussion is selected from the Case Records of the Massachusetts General Hospital, and reprinted from the New England Journal of Medicine. The discussant under Differential Diagnosis is a member of the staff of the Massachusetts General Hospital. The other discussants are members of the Phoenix Clinical Club.

Dr. Charles A. Noble*: This case is that of a sixty-two year old married expressman who entered the hospital complaining of cough of six months' duration and hemoptysis of two weeks' duration.

Two years prior to admission he had marked dyspnea on exertion. Six months before admission he began to have a racking non-productive cough. Three months before admission his cough became worse and was accompanied by a sensation of a lump in his throat. His coughing was accompanied by a good deal of shaking of the body, shaking of the chest, the attacks coming on three to five times a day. He developed sweating and occasional attacks of vomiting. Two weeks before admission he first spat up a small

*Recently senior interne on the East Medical service.

amount of blood during one of his coughing attacks. A week and a half before admission he noted enough weakness to make him stop work. Five days before entering the hospital he was awakened during the middle of the night by a feeling of fullness in his mouth and spat up half a pint of bright red blood. From that time he continued to cough up small amounts of bright red blood. There was no pain, but an occasional sense of soreness chiefly in his left chest, during a coughing attack. He lost his appetite. He had lost 12 pounds in the past year and some 40 pounds in the past three years.

He had been married for thirty-five years and had four children living and well. His wife was in fairly good health except for diabetes. He denied Neisserian infection and lues by name and symptom.

He entered the hospital showing evidence of weight loss. He was only moderately well developed. The pupils reacted to both light and accommodation. The arteries of the discs showed sclerosis and there were early cataracts of both eyes. There was quite striking leukoplakia of the tongue. The heart was normal so far as could be demonstrated. The blood pressure was 130/65. There was extensive dullness in the left chest both anteriorly and posteriorly from the axillary line in front and from the midscapular region in the back with diminished breath sounds, voice sounds and tactile fremitus and occasional coarse rales and sibilant and sonorous rales. In the region of the left axilla in front there were increased breath sounds, bronchial in quality, almost cavernous. There was no egophony. No Corrigan pulse was noted. Under examination the peripheral vessels showed definite sclerosis, perhaps not more than is to be expected in a man of his age. The ankle and knee jerks were normal.

The red blood count was 3,750,000, the hemoglobin 75 per cent, the white blood cell count 9,550. There was a normal differential count and slight achromia on smear. The urine and stools were negative. Two sputa were negative for tubercle bacilli and spirochetes. The Wassermann and Hinton reports, which came back after the patient had died, were both strongly positive.

The x-ray report, which came back to us also just before he died, was quite suggestive, almost definite for aneurysm of the middle of the arch and the first part of the descending portion of the aorta, although on admission he had been sent to us with a diagnosis of primary carcinoma of the lung, and until that x-ray report came back that was the diagnosis that was favored in the ward.

Two days after admission, after a normal chart and after coughing a small amount of blood, he suddenly had a massive hemoptysis and died within a few minutes.

DR. FRANK J. MILLOY

This is a very interesting case involving the differential diagnosis of hemoptysis in a 62 year old, married expressman. It also revives an old query of whether one ever dies directly of their syphilis. I believe the answer is occasionally, and I believe that his man did. I am reminded—so I think the discussion can be simple by staying with the evidence of syphilis as presented in the history, or it can be made difficult by trying to add other pathology. This is the 5th case for discussion here this year with a positive Wassermann. Two of the patients died of syphilitic processes. One had an obscure etiology. And one had a malignancy. At another hospital this case was diagnosed carcinoma of the lung. At this hospital the diagnosis was changed to a ruptured aneurysm after the x-rays were seen.

Dr. Cabot compiled the statistics on 3,306 cases of hemoptysis in Massachusetts General Hospital in his book which was published in 1914 and they are worthy of note: Tuberculosis 1,723; Mitral Disease 1,123; Unspecified Cause 183; Pulmonary Thrombosis or Embolism 141 Pulmon;-ary Abscess or Gangrene 77; Bronchiectasis 58; Pneumonia 52; Anerysm 22; Trauma 17 and Neoplasm 6. Making a total of 3,306.

The first impression of these statistics is that cancer of the lung must have been rare in Dr. Cabots time.

A 62 year-old man with a history of good health and 2 negative sputum tests for tubercle bacilli very likely does not have pulmonary tuberculosis. The protocol states that 2 years before admission the patient had marked dyspnea on exertion. Then 6 months before admission he began to have a racking non productive cough. Three months before admission his cough became worse. Two weeks before admission he raised his first blood. Ten days before admission he stopped work. And four days before admission he had his first real hemorrhage. He had no pain and lost his appetite. He lost 40

pounds in 3 years, 12 in the last year. He had a positive Wassermann. He was married at 27 and his wife and 4 children were healthy so he must have contracted his primary infection quite early in life.

The striking leukoplaskia on the tongue indicates latent lues. The advanced sclerosis of the peripheral blood vessels, and the blood vessels in the eye grounds fit the picture. The racking, rasping non productive cough is the cough of aortic aneurysm. The x-ray taken in the hospital was almost definite for aneurysm of the middle of the arch and the first part of the descending aorta. Aneurysm of the arch of the aorta has been called the aneurysm of symptoms. And this man had plenty of symptoms. With the diagnosis of aneurysm so obvious, I am wondering for what good reason we are being called to discuss this case here. At any rate he had an extensive pathological process in the left lung. There was extreme dullness from the axillary line in front to the midcapular line posteriorally. There were occasional rales and there were sibilant and sonorous rales. In the left axilla in front there were increased breath sounds, bronchial in quality, almost cavernous.

The subject of syphilis of the lung is an interesting one. It is particularly conspicuous by its rarity. Osler found only 12 cases in 2,800 necropsies at Johns Hopkins Hospital and 8 of these were congenital. Symmers found 12 cases in 4,880 necropsy, Protocols and Clayter could not find a single example of lung syphilis in 13,000 specimens at the Army Medical Museum in Washington.

On the other hand Funk found 4 cases of pulmonary syphilis in 1,200 supposedly tuberculosis patients admitted to Jefferson Chest Hospital. Greerman investigation of 817 patients applying for examination at the Dispensory of the Anti-Tuberculosis-League in Houston, found 145 with positive Wassermann tests, and of these, 39 were non tuberculous. In 2 of these he felt justified in making a diagnoses of pulmonary syphilis, though he believed more of the 39 had pulmonary syphilis. Wile and Marshall write as follows: "In its various forms, syphilis of the lung may present itself with a clinical picture of any phase of pulmonary disease. For this reason the condition probably exists to a greater extent than is indicated by either clinical or pathological reports. Karschner and Karschner state: From an extensive survey of the literature and from our own clinical experience we feel that cases of syphilis of the lung are quite common and, if recognized, often give rise to therapeutic surprises. Munro found 6% of 100 cases admitted to Glenlomand Sanitarium had syphilis of the lung. In 209, or over 22% of 948 patients with advanced tuberculosis, Watkins (and the initials are W.W.) made a diagnosis of combined syphilis and tuberculosis from the roentgenograms in association with the clinical symptoms. O'Leary reviewed the records of 60 patients referred to his section at the Mayo Clinic over a period of 20 years because of the suspicion of syphilis of the lung and could find only 4 cases of the entire group that proved to be pulmonary lues. Carreva studied the lungs of 152 syphilities. He found positive evidence of pulmonary syphilis in 12 cases. He states that the diagnosis of pulmonary syphilis must be made microscopically. He divided the 12 cases as follows: 1. Gumma of lung 3 cases; 2. Syphilitis peribronchitis and arteritis 2 cases; 3. Syphilitic Fibrosis and arteritis 4 cases; 4. Syphilitic arteritis. Total 12 cases or approximately 8%. To sum up the literature on acquired pulmonary syphilis, something over 200 cases have been reported, but only a minority have been confirmed by autopsy. Most of the references which I reviewed consisted of a report of one case and most of these cases appearing in the literature have been diagnosed on the basis of clinical evidence.

So that after all the diagnosis is presumptive. The ultimate proof is demonstration of the treponema pallidum in either the tissue or the sputum. This has been possible in but few of the 200 cases reported but it was done in one patient who had a lobectomy performed.

The outstanding symptoms of syphilis of the lung are: (1) cough—likely to occur in paroxysms —may be very dry and racking—later may become very productive. (2) Sputum—usually mucopurulent hemorrhage occur in about ⅓ of all cases. It was almost a constant finding in the case reports I reviewed. Most important finding is abscence of tubercle bacilli.

DYSPNEA is a prominent and important symptom. Much more common than in tuberculosis. Our patient had it for a while two years before admission to the hospital.

PAIN is more pronounced than in tuberculosis. Fever, night sweats, emaciation occur in 40%.

PHYSICAL SIGNS: Any combinations of

physical signs of the chest may be demonstrated. The most remarkable thing about the physical signs, which may include the x-ray findings also, is that they may be all out of proportion to the patients clinical symptoms. That seems to be the situation with our patient today. He had an attack of dyspnea 2 years before entrance to the hospital. The history does not state how long it lasted. Then six months before entry the cough appeared. It was a racking non productive cough, paroxysmal in character. He lost 40 pounds in 3 years—12 pounds in the past year.

In spite of all these symptoms the man did not quit work until 10 days before entry to hospital. And it apparently was the sight of blood in his sputum on two occasions that prompted him to seek medical aid. And during the two days in the hospital he had a normal chart, except for coughing up a small amount of blood once. Then he suddenly had a massive hemorrhage and died.

Rentgenologic examination gives no more distinctive evidence than the history and physical examination. In the early stages Watkins (again the initials are W.W.) described confluent shadows of varying density inclined to irregularity and massiness of the edges, tending to mass along the heart border and the larger bronchial trunks. Gummata he states, will cast shadows irregular in size, with edges not clear cut, but more so than those of consolidations, with centers of diminished density when caseous, and pointed projections of fibrous tissue when healing. Syphilitic fibrosis produces shadows consisting of striations arising from dense hilus shadows and radiating to the periphery.

Golden lists the following as of value in the x-ray diagnosis of pulmonary syphilis. Syphilis usually affects the lower part of the lung, seldom invades the apex. The process is apt to be more marked about the hilus, progressing from this part of the lung along the bronchi to the periphery. It tends to develop unilaterally and may completely destroy the functions of one lung, involving the other comparatively little or none at all. It involves the pleura extensively and causes marked connective tissue reaction producing radiating or stellate scars which may be extensive and which rarely calcify. To Summarize:

1. Very few cases are proved pulmonary lues by demonstration of the terponema pallidum.

2. By far the greatest number of cases are proved by the result of the therapeutic test.

3. The most important differential determination is whether the case in question is syphilis or tuberculosis.

4. And the next most important is whether both syphilis and tuberculosis are present. In the old days a patient with active pulmonary tuberculosis had a positive Wassermann and was given arsphenamine, death usually intervened in short order. The advent of bismuth made it easier to treat such cases. I do not know the effect of the antibiotics on such cases.

5. Pulmonary lues occur in two forms.
   1. Syphilitic gummata.
   2. Syphilitic fibrosis.

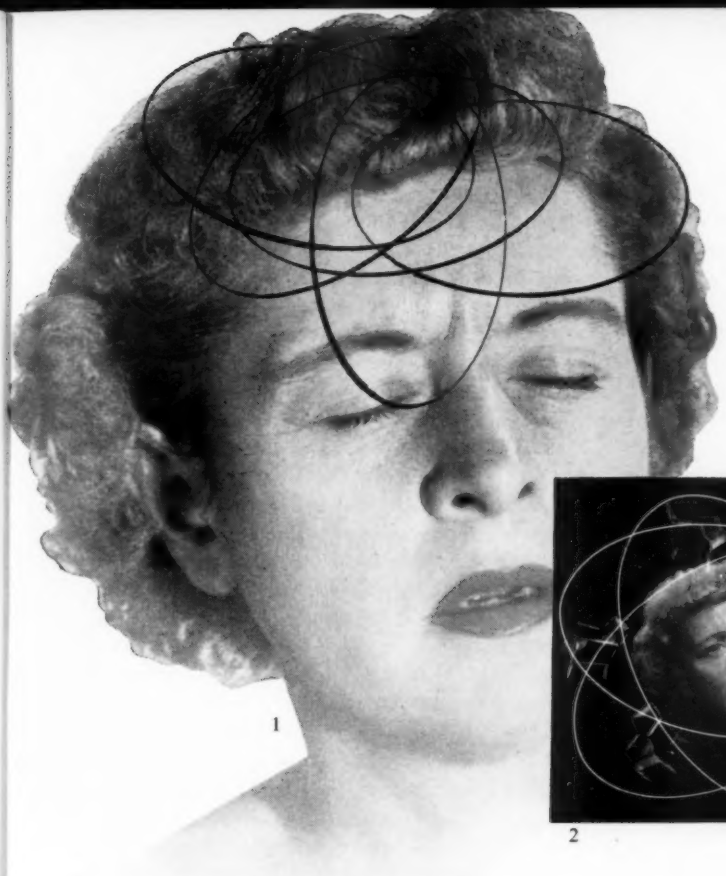
The prognosis of pulmonary lues is fairly good and responds fairly well and rapidly to specific treatment unless too much fibrosis has developed. If this patient had been less unfortunate and had not suffered a fatal hemorrhage he might have recovered from his pulmonary lues. That is unless he had an aneurysm instead.

I believe this man died of a syphilitic process and it was either a syphilitic gummatous process of the lung or a ruptured aneurysm of the aorta. Gumma of the lung is much the rarer condition. So I believe it is more likely to be a ruptured aneurysm.

CLINICAL DISCUSSION

Dr. William David Smith: I have not much to add to the discussion. He came in as a case of hemoptysis for diagnosis and until he had the laboratory work there was essentially nothing on which to make a diagnosis of aneurysm so far as the heart was concerned. The signs were pulmonary rather than cardiac. I suppose even before he had a Wassermann or an x-ray the leukoplakia might have made us a little more suspicious, for while leukoplakia can occur in smokers it is more common in syphilitics. There was nothing in the examination of the heart to lead us to think there was either syphilitic aortitis or aneurysm.

Dr. George W. Holmes: The x-rays of course show a very definite mass in the chest. The only question is whether it is aneurysm or tumor. The thing which confused us a little was the dullness at the root of the lung. That might have been interpreted as a primary carcinoma of the bronchus with metastases to the glands along the trachea or it might have been interpreted as an aneurysm of the descending aorta with pressure on the bronchus producing atelectasis. As I remember it there was no pulsation of the



1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*

2

3

TYPES OF VERTIGO:

Their symptomatic relief with Dramamine®

The disagreeable sensations of dizziness which physicians are frequently required to explain to patients have been described by Simonton[1] as varying from a slight sensation of confusion to severe vertigo.

While dizziness or giddiness is classified as a sensation of unsteadiness with a feeling of movement within the head, in vertigo the environment seems to spin (objective vertigo) or the body to revolve in space (subjective vertigo). Labyrinthine disturbances are likely to cause a sensation of rotation. Among the more common causes of dizziness or vertigo, this author lists: Damage to the vestibular nuclei or tracts in the central nervous system, involvement of the vestibular end organs by disease of the ear, Ménière's disease, toxicity of drugs, ocular vertigo from sudden diplopia, visual field defects, looking down from heights and motion sickness due to hyperactive labyrinthine reaction from riding in vehicles.

Dramamine (brand of dimenhydrinate) has proved effective in treating many of these disturbances. The indications for which Dramamine is now Council accepted include: Motion sickness, the nausea and vomiting associated with pregnancy, certain drugs, electroshock therapy and narcotization; vestibular dysfunction associated with streptomycin therapy; the vertigo of Ménière's syndrome, hypertensive disease and that following fenestration procedures, labyrinthitis and radiation sickness.

1. Simonton, K. M.: The Symptom of Dizziness, Arizona Med. *6*:28 (Sept.) 1949.

SEARLE *Research in the Service of Medicine*

tumor by fluoroscopy. The presence or absence of pulsation of x-ray examination is very unreliable anyway. Some tumors that are aneurysms do not pulsate. In the oblique position the lesion seems to be distinctly associated with the aorta and is of a fusiform character rather characteristic of aneurysm. It does not seem likely that a mass in the region of the hilus would follow the aorta as well as that does and produce such a fusiform shadow. There is absence of lobulation, a point which would also be somewhat in favor of aneurysm. The diaphragm is high on the left side and the left lung field is smaller than the right, also evidence in favor of pressure on the bronchus. We felt that it was more likely to be aneurysm than tumor. The abscence of any change in the heart shadow does not help much one way or the other. In luetic aortitis with aortic regurgitation and involvement of the aortic valve we should get a picture of enlarged heart with the characteristic shape; but in the absence of involvement of the valve the heart is usually normal.

Dr. John I. Bradley: Can you identify the bronchus to the left lower lobe in this film?

Dr. Holmes: There is some evidence of pressure on it. The left descending bronchus is not very well shown, but I think there is some narrowing of the trachea at this point.

X-RAY INTERPRETATION

The findings are probably due to aneurysm of the arch of the aorta with bronchial compression and partial collapse of the left lower lobe.

CLINICAL DIAGNOSIS

(From Hospital Record)

Aneurysm of the aorta, ruptured.
Possible carcinoma of the lung.

ANATOMIC DIAGNOSIS

Syphilitic aortitis.
Aneurysm of the thoracic aorta with rupture into the left bronchus.
Bronchopneumonia, bronchiectasis, lower lobe of the left lung.

PATHOLOGIC DISCUSSION

Dr. Bradley: At autopsy we found a mass corresponding to this shown by x-ray and continuous with the aorta. The right lung and the upper lobe of the left lung were about normal in size, perhaps slightly distended and emphysematous. The left lower lobe appeared relatively small. It was firm, adherent laterally to the parietal pleura, and the pleura was very much thickened. We found the descending branch of the left bronchus going to the left lower lobe adherent to the wall of the aortic mass. On opening the bronchus we found a defect in the anterior wall of the bronchus roughly a centimeter in diameter which was plugged with a mass of soft friably grayish material. On opening the aorta we found a fusiform aneurysm of the thoracic aorta beginning approximately in the region of the arch and extending down to the lower portion of the thoracic aorta, covering a distance of about 12 centimeters. The wall of the aneurysm was quite thin. There was over a good part of it a thick layer of laminated clot. In the medial part of the wall of the lower third of the aneurysm there was a relatively large defect about 2 centimeters in diameter occluded by a fairly recent thrombus. This defect lay just over the defect in the bronchial wall. It is apparently the explanation of the massive hemoptysis.

On section the left lower lobe showed interesting changes. In the central portion of the lung just below the area where the bronchis is adherent to the aneurysm there are a number of dilated spaces, apparently dilated bronchioles. Around them the lung tissue is firm, yellowish-white and fibrous. On the outside of that zone of fibrous tissue around the dilated bronchioles there is an irregular patchy area of consolidation.

The aorta at either end of the aneurysm showed changes typical of syphilitic aortitis. There were several small saccular outpocketings about 3 to 4 millimeters in diameter and about the same depth in the first portion of the aorta, apparently beginning aneurysms. The aortic valve showed practically no involvement, merely a slight separation of the attached margins of the cusps. The changes however were not sufficient to produce any functional impairment. The heart itself was negative.

Dr. James H. Means: The history is of interest from the point of view of diagnosis. The cough as I understand it was paroxysmal from the beginning, with a good deal of distress and with some choking attacks at night. That and his having hemoptysis later would suggest aneurysm perhaps more than anything else.

Dr. Frederick T. Lord: The complex of symptoms here is, I should think, fairly typical of aneurysm, which is not a common cause of bleeding. When bleeding does occur with aneurysm it is not ordinarily "out of a clear sky".

There is one case in the autopsy records of interest in this connection. This was a man

of thirty-seven with cough without expectoration for three years and an abundant hemoptysis three days before entrance. A recurrence of the bleeding was fatal two days after admission. At autopsy a large branch of the pulmonary artery was found to have ruptured into the right primary bronchus through a cicatrix involving the wall of the artery. Other cicatrices in the trachea and the left primary bronchus together with interstitial orchitis suggested syphilis as a cause.

The present case illustrates the importance of x-ray in diagnosis. Without it, and with small amounts of bleeding and a suspicion of tumor, bronchoscopy might be attempted, but with great risk of fatal hemorrhage in consequence of the procedure.

The physical signs are of interest in this case. The same complex of signs is common to bronchial occlusion arising from within and compression from without; i.e., dullness, diminished or absent breathing, voice, whisper and tactile fremitus. If the bronchus is partially occluded, sibilant rales are likely to be present on one side of the chest and may serve to suggest the presence and site of the bronchial occlusion, as is often observed with tumors invading the lumen of a bronchus.

Dr. Holmes: The autopsy findings raise an interesting question in regard to the x-ray film. The bright area in the left lung extends to the base so that we see the outline of the diaphragm. If the entire left lower lobe is dull, with no air in it, it is a little difficult to explain the brightness in the lower part of the chest. I suppose it is due to overlapping of the upper lobe.

Dr. Bradley: There is another possible explanation for that bright area. The appearance of the lower portion of the left lower lobe was different from that of the remaining consolidated areas. There the lung is distended, firm, dark red, and the appearance on gross examination is that of hemorrhagic infiltration rather than of pneumonic consolidation. It may possibly represent a terminal change.

Hill-Burton Hospital Construction

Status of all Hill-Burton hospital construction in Arizona at the present time is as follows:

Complete and in Operation: 7 projects at a total cost of $3,340,501.00, including federal contribution of $1,132,516.00, and supplying 246 additional beds.

Under Construction: 5 projects at a total cost of $7,867,531.00, including federal contribution of $2,232,051.00, and designed to supply 599 additional beds.

Approved, but not yet under construction: 2 projects at a total cost of $552,061, including $90,445 federal contribution and designed to supply 64 additional beds.

The PRESIDENT'S *Page*

DOCTOR DRAFT LAW

Of primary interest to all doctors is the enactment of Public Law 84, 83d Congress, signed by the President, June 29, 1953, extending until July 1, 1955, a revised version of the DOCTOR DRAFT LAW. Briefly, provisions of the new law are:

(1) Extend the effective date of the DOCTOR DRAFT LAW until July 1, 1955;

(2) Retain the maximum ages specified in existing law: Registration, age 50; Liability for induction, age 51;

(3) Continue in effect the four priorities established by existing law with the following amendments:

(a) All service performed since September 16, 1940, as an officer or as an enlisted man, with certain exceptions which will be outlined later, will be credited as service. At the present time doctors in priorities 1 and 2 only received credit for service performed "subsequent" to deferment or participation in a Navy V-12 or Army Specialized Training Program during World War II;

(b) The length of service required to qualify for priority 4 for doctors who were deferred or educated at government expense during World War II is reduced from 21 to 17 months. As a result of this provision a substantial number of doctors will be reclassified from priority 2 to priority4;

(c) Establish the following new periods of service for men recalled to active duty or inducted pursuant to the DOCTOR DRAFT LAW:

Previous Service	*New Period of Duty*
9 months or less	24 months
9 to 12 months	21 months
12 to 15 months	18 months
15 to 21 months	18 months

(d) Removes the liability for induction or recall to active duty, except in time of war or national emergency hereafter declared by Congress, for those men in priority 4 who have had 21 months or more of service since September 16, 1940.

(4) Define "active duty" and "Active service" to include:

(a) Full-time duty in the active service of the United States since September 16, 1940, in the Army, Navy, Air Force, Marine Corps, Coast Guard or United States Public Health Service, including reserve components;

(b) Time spent during World War II in work of national importance by conscientious objectors;

(c) Service performed before September 2, 1945, in the Armed Forces of countries which were allies of the United States during World War II; and

(d) Service performed as a physician or dentist by United States citizens employed by the Panama Canal Health Department between Septemper 16, 1940, and September 2, 1945.

(5) Exclude from consideration as "active duty" periods spent in a Navy V-12 or Army Specialized Training Program; in a military internship, residency or senior student program; in military service for the sole purpose of undergoing a physical examination or while engaged in active duty for training entered into after June 29, 1953;

(6) Authorize the appointment of medical officers in grades commensurate with their professional education, experience or ability. This section is intended to provide for uniform treatment with respect to the ranks of all doctors called to active duty irrespective of whether they had previous military service;

(7) Continue until July 1, 1955, the authority to provide the "Special Pay" of $100 per month for doctors in the Armed Forces. This section also extends the class of persons eligible for such pay to include veterinarians;

(8) Authorize the commissioning of non-citizens of the United States as officers in the Armed Forces;

(9) Terminate automatically, upon completion of 12 months or more of service subsequent to September 9, 1950, the reserve commissions of all physicians taken into service by operation of the DOCTOR DRAFT LAW. Upon completion of this same service medical reservists recalled to active duty will be given an opportunity to resign their commission. Such persons, whether registrants or reservists, shall not be liable thereafter for recall or reinduction except in time of war or national emergency hereafter declared by the Congress;

(10) Re-enact the present provisions of law which permit the deferment of those individuals who are essential to the national health, safety and interest;

(11) Authorize the national, state and local medical advisory committees to the Selective Service System, in addition to their present authority, to make recommendations with reference to the deferment of (a) registrants engaged in residency training, (b) those serving on faculties of medical and certain other schools and (c) those engaged in essential laboratory and clinical research;

(12) Extend until July 1, 1955, the authority of the President to recall medical reservists to active duty involuntarily;

(13) Be retroactive in effect. Those men already in uniform who would have benefited from the new changes in the law will, upon filing an application, be eligible for release from service as soon as possible and in no event later than 90 days after the effective date of the Act (June 29, 1953).

Edward M. Hayden, M.D.,
President

Editorial

ARIZONA MEDICINE

Journal of

ARIZONA MEDICAL ASSOCIATION, INC.

VOL. 10 JULY, 1953 NO. 7

CONTRIBUTORS

The Editor sincerely solicits contributions of scientific articles for publication in ARIZONA MEDICINE. All such contributions are greatly appreciated. All will be given equal consideration.

Certain general rules must be followed, however, and the Editor therefore respectfully submits the following suggestions to authors and contributors:

1. Follow the general rules of good English, especially with regard to construction, diction, spelling, and punctuation.
2. Be guided by the general rules of medical writing as followed by the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. (See MEDICAL WRITING by Morris Fishbein.)
3. Be brief, even while being thorough and complete. Avoid unnecessary words. Try to limit the article to 1500 words.
4. Read and re-read the manuscript several times to correct it, especially for spelling and punctuation.
5. Submit manuscript typewritten and double-spaced.
6. Articles for publication should have been read before a controversial body, e.g., a hospital staff meeting, or a county medical society meeting.

The Editor is always ready, willing, and happy to help in any way possible.

GRIEVANCE COMMITTEES

Three years have elapsed since the establishment of Grievance Committees in Arizona. The experience of these committees is of interest to the profession throughout the state.

As far as Maricopa County is concerned no instance of litigation against a doctor has followed action on grievances, which indicates that these committees tend to protect the doctor. This would not have been the case had there been any serious deficiencies in the treatments rendered patients. The primary purpose of these committees is to safeguard the public, and should serious overchange occur, or serious deviation from accepted standards of treatment occur, or should the doctor be unwilling to make adequate adjustment, the committee can and will aid the patient to a correct solution of the difficulty even to furnishing expert testimony in court if needed.

The committee has had complete co-operation of the medical profession, and in no instance has there been any need to utilize more than reason with our doctors. This is probably due to the painstaking studies made of each grievance, and the general fairness of the decisions rendered.

Most complaints are concerned with charges for service, and in most cases the complaint has been made to the committee without first approaching the doctor for discussion of the fee. Due to this, at least in Maricopa County in the future, no grievance will be considered by the committee concerning charges, until the patient has had an "across the table" discussion of the fees for service, and been unable to obtain satisfactory settlement. It is felt that by understanding the nature of the work done and charges made, that most fee disputes can thus be obviated; also, the patient can make known elements of hardship which the doctor might not be aware of, by this means.

Certain general deductions can be made concerning charges from the experience of these committees. Too much itemization of charges may lead to complaint, and strangely enough more complaints arise over medical than over surgical services. The method of the surgeon might be utilized then in order to reduce dissatisfaction. In other words a statement might read "for the treatment of coronary occlusion," or "of lobar pneumonia" or "of meningitis" such and such a charge, rather than itemizing for each hospital, office or residence visit. Certainly prolonged attendance should be mentioned if charge has been made for it, and probably separate laboratory charges should be designated. In

other words focus on the serious condition treated and your responsibility therein might well justify the charge, when a fee for an individual call might seem excessive to the patient. It is true that insurance requirements may make this inadvisable.

Some complaints arise from failure of a physician to inform consultants of patients financial condition. If a consultant charges too low a fee in relation to the attending physicians, the attending physicians fee maybe placed in jeopardy even though entirely proper.

Some grievances arise because doctors do not take time to bring to their patients attention the amount of work done and the value of the services. Certainly a physician's services are the equal of that of the carpenter, bricklayer, or plumber—many disputes would not arise if these facts were shown the patient.

Several complaints have resulted when a patient refused consultation recommended by the attending physician and a not entirely satisfactory result ensued. In these instances the doctor is probably better off to refuse further care of the case, realizing an unsatisfactory progress had been made, rather than go on. The committees have emphatically scolded these patients for their refusal to accept consultation, and pointed out to them that they have themselves to blame only. Some complaints have been found due to failure of patient to follow instructions, and these patients have been informed of their own failures as the cause.

Obviously women should never be examined without a nurse or third person in attendance. Committees are powerless to protect doctors from malicious statements unless the doctor guards himself. A jury would likely be glad to bring a verdict in behalf of an attractive female, if it came to the doctors word against the patients.

Partnership agreements should be in every detail in writing. Grievances due to this lack of foresight have been processed.

The committees cannot countenance failure of the attending physician to make requested call on the death of his patient, no matter what the hour. The physician owes this to the deceased's family if his presence has been requested.

Improper evaluating of conditions over the phone has led to grievances. Patients of long standing have recorded grievances when a doctor has failed to make a requested call. If a doctor feels powerless to help these patients of long standing further, he should either dismiss himself from further responsibility, or obtain a substitute for himself if he cannot make the call. If conditions come to a standstill often a suggested consultation is a way out of a dilemma.

In General the Grievance Committees have exerted a powerful influence in behalf of the medical profession. The mere presence of a grievance committee will tend to serve as a check rein on the occasional doctor who might be tempted to deviate from accepted practices inasmuch as the committee will help any mistreated patient. Again the committees protect the doctor whose work is conscientous, honest and long acceptable standards, and by this they serve as a powerful deterent against the institution of legal action without reasonable cause.

LETTER TO THE EDITOR

SOCIETY FOR THE BRAIN INJURED FORMED

Samuel R. Joseph, M.D.
Phoenix, Arizona

Recently a letter of application was sent to the Arizona Medical Society requesting sponsorship of The Arizona Chapter, National Society for The Brain Injured. The need for such an agency is apparent when we realize the great number of Brain Injured who are at present neglected and forgotten by society.

The organization was founded in California by professional people, interested parents and businessmen. There are two chapters in California, one in Arizona, Texas, Illinois and New York. It is hoped that eventually there will be a chapter in each of the forty-eight states.

The aims of the organization are to establish a model school; to establish a clinic for Brain Injured; to promote a parent guidance program; to foster and aid research; and to give assistance to disaster areas such as might occur where an epidemic of encephalitis and meningitis may break out.

The group considered would be the ambulatory Brain Injured such as epileptics, brain injury from birth, brain injury from infectious diseases such as meningitis and encephalitis, and traumatic brain injuries. This includes a large number of our children and adults who are not cared for by such agencies as the Cerebral Palsy

and Crippled Children's organizations, who include spastics.

It is estimated that 60% of these children can be rehabilitated and trained to lead near normal, productive lives. Our schools are not equipped to accept these children who require highly specialized training. There are few text books written on how to teach them and there are few trained personnel to train them. These children have long been forgotten.

Our organization hopes to be of service to the Brain Injured, to the parents and relatives of the Brain Injured and to the physicians who are confronted with this problem. All of us, as physicians, have had the parents of Brain Injured seek us for advice. In the past, since there are so few facilities, all we have been able to tell them is,—"Put them in an institution or take them home and forget about them." The physicians must help these parents to adjust to their problem. The medical specialist must recognize the need for this understanding. Thousands of parents each year face the difficulties involved in rearing a Brain Injured child. It is estimated that these are 1,000 of these unfortunates for each 100,000 population.

You, as a physician, must have keenly felt your inability to help the parents of a Brain Injured when they come to you for advice. Our knowledge is limited, the agencies set up for us to recommend these parents to are few. Our profession has a duty to these people. Until now, as a group, we have let them down by not having anything encouraging to say, nor very much constructive to suggest. Only the parent of a Brain Injured can know the deep hopelessness and despair when their friend and family physician or pediatrician tells them to "Send the child away and forget about it. Nothing can be done." But something can be done and will be done. You will soon be in a position, with the help of the Society For The Brain Injured, to refer these parents to an agency who can help you diagnostically, help you ease these parents over the shock and through a period of adjustment following the knowledge that their child is Brain Injured; as well as help you treat, rehabilitate and teach these children. It is a tough decision for a physician to make, whether to tell the parents that a child is Mongoloid or that the child's injury or disease has resulted in mental retardation. We hesitate to tell the parents only because we had no hope ourselves and had no place to tell these parents to take their child. Now there is hope for many.

Our organization seeks to give hope to the physician, the child and parents by the fulfillment of our aim. We physicians must recognize the need for this organization and cooperate by recognizing and sponsoring it. Recently you received a letter asking for a list of those you have among your patients who are Brain Injured. We offer our help to you with these patients, but we must know who they are and how many we have in this State. We need to have some idea of how many and what types of cases there are before we will be given Clinic time and space in one of our hospitals. Those of you who have not sent a list of names before this please address it to:

Samuel R. Joseph, M.D.
711 West Thomas Road
Phoenix, Arizona

The Arizona Chapter of the National Society for Brain Injured announces to the Arizona Medical Society that the National Society's home office at Los Angeles has established a special ten week training course for Brain Injured children from 7 to 12 years of age. Any doctor who receives this message may recommend a child for this special program. The school will be under the direction of Miss Jean Owen, who has been trained by Dr. Strauss of the Cove Schools and by Dr. Parmalee in Chicago. This remedial program will be for children diagnosed as brain injured but teachable. Because of the physical nature of the school facility to be used, brain injured children must be ambulatory and have not more than 15% orthopedic handicap. The local Chapter will sponsor one scholarship, in whole or in part. For further information write to the National Society for Brain Injured, Arizona Chapter, 3007 North 9th Avenue, Phoenix, Arizona.

TOPICS OF *Current Medical* INTEREST

RX., DX., AND DRS.

By GUILLERMO OSLER, M.D.

Are you up on DISKOGRAPHY? The method has nothing to do with the distribution of flying saucers, but is an orthopedic technic of Swedish origin (Lindblom, 1948). . . . An intervertebral disk seems an unlikely place to put a needle and to inject a radiopaque fluid, but that is the objective. . . . The diagnostic data are obtained from the amount of pressure needed to inject, the presence of sciatic pain at injection, and the x-ray appearance.

TRICHINOSIS is not commonly diagnosed, yet there are said to be 350,000 new infections in the U. S. each year, for a total of 25,000,000. . . . Fifty-four larvae per gram of diaphragm muscle is the level at which symptoms may be produced. About 16,000 new cases should have symptoms (4.5%), but only an average of 336 cases per year are reported. . . . About 1.5% of 60,000,000 hogs slaughtered each year are infected.

A new idea has just been suggested for control of trichinosis,—all pork could be briefly exposed to ATOMIC RADIATION. The trichina would not be killed, but their reproduction would be prevented. So far it is a 'good' theory, since it is logical and has not been injured by trial.

It is amazing how one NEW DRUG happens to be handled by a man with a quiet type of personality and the course of its use is smooth and benign. Another new drug exists in the midst of a cops-and-robbers atmosphere, investigations (mystery, acrimony, etc., from the very start. . . . Look how many people in South and North America have suddenly gone off their course after coming in contact with Krebiozen. Dr. Ivy always liked to tilt at a windmill, liked to evangelize a bit, was a bit stubborn, but he and the drug together seemed to produce a fission like atomic energy.

The problem of REFUSE DISPOSAL isn't very well organized in the minds of most people, even of us medicals. A sanitation expert, however, can break it down into a half dozen aspects as fast as he can talk,—flies; rodents; air pollution; water pollution transportation nuisance; effect on topography; and sub-heads for all of the major items on the list.

—TIME Magazine reports the combined Arizona and USPHS investigation of CANCER AMONG THE NAVAJOS. . . . Dr. Clarence Salsbury noted that the Indians (of which he once took care) had less cancer than the nearby white people (of which he now takes care). In 23 years he never saw a breast cancer in Indian women. . . . We have also received a clipping of the report which Dr. Salsbury made in California to the western branch of a national hygiene society on the same subject. . . . Now Dr. S. can determine whether it is immunity or observation.

Have you X-RAYED ANY STAMPS lately? Philately, that is. . . . The General Electric monthly publication describes an exhibit by two modern stamp experts, in which their several methods have prevented fraud by showing watermarks, repairs, etc. Very complicated technique, but the stamps do not have to be removed from the valuable covers, and it makes a stamp-collector very scientific.

It is also fairly common knowledge that metal structures can be examined and diagnosed by x-raying. . . . Most people, however, would balk at a story of PLUMBERS USING STETHESCOPES to find water-pipe leaks, but we have a picture from a hospital journal showing a portly engineer in a Chicago hospital listening intently to a pipe with his needle-pointed 'bell'. A serious expression is balanced by a turned-up beak on his cap.

A couple of years ago an interesting theory was described in a paragraph in this column. LYSOZYME was then a recently described enzyme present in tears, the intestinal tract, etc. It was considered a possible cause of ulceration in the tract, especially in the colon. . . . Not so, say Meadows and Levison. They have found no mucolytic action, no destruction of the protective coating. Lysozyme may be an index of inflammation, however. . . . The people who once went 'Thru The Intestine With Gun and Camera' now have lysozyme as a new estimate of the local flora.

'BACKWOODS RESEARCH' is not so common, not so productive, not easy to justify, and not always strictly honest. . . . Sometimes the end justifies the means. If you have a disease for which there is no effective therapy (such as disseminated coccidioidomycosis), and a man who sees a great many hopeless cases (such as Dr. Robert Cohen of Tulare County, Calif.), it would seem that almost any 'possible' method would be worth while. . . . After going thru nearly twenty drugs in the past few years, and being hopeful about each one, he is now hopeful about ethyl vanillate.

About thirty companies have been writing most of the MAL-PRACTICE INSURANCE in the past. Their rates were highly variable, and hard to justify. . . . They are now joining together to write a standard policy and premium schedule. . . . The mutual companies and the companies not affiliated with the new plan will not be affected—and their rates will not take the small but inevitable jump which seems to follow organization.

Hyde and Hyde of Los Angeles have described 120 consecutive cases of nontuberculous, nontraumatic benign SPONTANEOUS PNEUMOTHORAX. They recommend bedrest only. . . . Their reason for expectant therapy is that only 19% recur, and more than 2 recurrences are rare. . . . Some people would want more action, but the series seems worth considering.

It was interesting to see a picture (in A. P. H. News) of Dr. Salsbury conferring with Dr. Albert Russell, new Arizona Director of TB Control. They were seeming to study the Citizens' Committee report, which stresses the need for about 1,000 additional beds for the care of active cases. . . . They could also be speculating on how to obtain the 150 beds which 'got off the hook' a few years ago. . . . We knew a doctor in 1945 whose solution of the problem would just fit the current needs,—A 1,000-bed TB hospital would be built about 3 miles outside the center of one of the Southern Arizona desert cities (not beginning with a 'P'). The hospital would be multi-storied, well-designed, and modern. It would take patients in three categories,—private; state-county; and federal. The basic care would be of the same high level for all, plus frills when paid for. There would be a resident staff, a visiting staff, and a medical control board. (The ice is thin at that point). A law would require that all active TB patients in the state be hospitalized, with some certain exceptions. The families could live nearby the hospital. The financing would be arranged by a combination of federal-state-county-private funds. People could come to Arizona for tuberculosis care, provided that they conformed to the law. They could live in Arizona after recovering. . . . This was a REAL good dream, but it might be more like a nightmare to some people.

Several years ago we surveyed the local and national attitudes towards use of ANTI-RABIES VACCINE in humans. There was great uncertainty then, with a tendency to feel that it had to be used because of demand rather than value. . . . A recent survey in New York City concludes that the danger from rabies is greater than the danger from vaccine side-effects. . . . The use of vaccine, however, should be restricted to those BITTEN. Contact with, or a scratch by, a rabid animal is NOT a good enough reason for treatment. . . . Now, who will believe it? . . . Also, when are those 'improved' vaccines going to be reported?

La Alianza Panamericana De Doctoras En Medicina Pan American Medical Women's Alliance, Inc.

IV Congress—Beekman Towers Hotel, First Avenue and 49th Street, New York City, September 24 through October 1, 1953, Dr. Ina A. Marsh, 140 Linwood Avenue, Buffalo 9, New York, Registration Chairman.

AMERICAN MEDICAL ASSOCIATION ANNUAL MEETING REPORT

Your Executive Secretary was privileged to attend the 102nd annual meeting of the American Medical Association held in New York City, June 1-5, 1953. As anticipated, it was the largest gathering in the history of the medical profession. Registration exceeded 18,000 member physicians, surpassing the record established in 1947 at Atlantic City, of 15,667, the occasion of the Association's centennial celebration. Approximately 20,000 additional attendance was likewise recorded, comprising medical students, medical society executives, wives of physicians and exhibitors' representatives.

The scientific program presented at general sessions and sectional group meetings held at the Commodore, Biltmore, New Yorker, Waldorf-Astoria, Belmont Plaza, Astor and Roosevelt Hotels, in addition to the Town Hall, included the presentation of approximately 400 papers covering every phase of medical research and therapy. The Grand Central Palace was the scene of scientific exhibits, the entire fourth floor being devoted to approximately 260, and three additional floors were occupied by over 375 drug, medical equipment and pharmaceutical manufacturers, food processors, medical book publishers and other commercial organizations comprising the technical exposition. About twenty-five motion picture films showing the latest techniques in the treatment of diseases and for the first time, televised surgical operations in color were shown.

The Conference of Presidents and Other Officers of State Medical Associations held its ninth annual meeting at the Waldorf, Sunday, May 31, attended by your Executive Secretary. Louis M. Orr, M.D., of Orlando, Florida, past-president of the Florida Medical Association, discussed "Medicine at the Crossroads—1933-1953"; Rev. Frank W. Price, D.D., of Richmond, Virginia, spoke on "Asia is on Fire—So What?"; Carroll M. Shanks of Newark, New Jersey, president of the Prudential Insurance Company of America, discussed "Voluntary Health Insurance—an Appraisal and a Look Ahead"; and the Honorable John Marshall Butler of Baltimore, Maryland, Senior United States Senator from the State of Maryland, spoke on "The Constitution and Treaty-Making Powers." The Medical Society Executives Conference held at Hotel Belmont Plaza, June 1, concluded its seventh annual meeting. This is a workshop for national, state and local medical society executives, and another educational program was conducted. Your Executive Secretary was a member of the Executive Committee during the year 1952-53.

The House of Delegates of the AMA met for the first time Monday morning, June 1, followed by several additional sessions and Reference Committee meetings. These meetings were marred only by the absence of our delegate to AMA, Dr. Jesse D. Hamer, who rushed to the bedside of his wife, seriously injured in an automobile accident near Aurora, Missouri, who was enroute to Springfield. Mrs. Clarice Hamer, national representative of this state to the Woman's Auxiliary, had planned to meet Dr. Hamer in Chicago, and together intended to fly to New York to attend their respective meetings. I am more than happy to report that it has been possible to move Mrs. Hamer to Phoenix, during the past week and at this writing, is progressing satisfactorily. I know we all wish her a speedy recovery.

Dr. Edward J. McCormick of Toledo, Ohio, President-Elect, was installed President of the AMA at a fitting inaugural ceremony in Hotel Commodore, Tuesday evening, June 2, succeeding Louis H. Bauer, M.D., of Hemstead, New York. On Thursday afternoon, June 4, Walter B. Martin, M.D., of Norfolk, Virginia, was elected President-Elect; Carl H. Gellenthein, M.D., of Valmora, New Mexico, Vice President; and re-elected were George F. Lull, M.D., of Chicago, Secretary; J. J. Moore, M.D., of Chicago, Treasurer; James R. Reuling, M.D., of Bayside, New York, Speaker, and E. Vincent Askey, M.D., of Los Angeles, Vice Speaker. Gunnar Gunderson, M.D., of La Crosse, Wisconsin, and Edwin S. Hamilton, M.D., of Kankakee, Illinois, were re-elected members to the Board of Trustees, and Julian P. Price, M.D., of Florence, South Carolina, for the unexpired term to fill the vacancy created by the elevation of Dr. Martin to President-Elect. Elected to the Judicial Council was George A. Woodhouse, M.D., of Pleasant Hill, Ohio; to the Council on Medical Education and Hospitals, Victor Johnson, M.D., of Rochester, Minnesota, and L. S. McKittrick, M.D., of Boston, Massachusetts, both re-elected; to the Council on Scientific Assembly, Hans H. Reese, M.D., Madison, Wisconsin, and Charles H. Phifer, M.D., of Chicago, Illinois; to Council on Medical Service, Louis M. Orr II, M.D., of Orlando, Flor-

ida, and Robert B. Homan, Jr., M.D., of El Paso, Texas; and to the Council on Constitution and By-Laws, Stanley H. Osborn, M.D., of Hartford, Connecticut, re-elected.

Guest speakers during the House sessions were Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare, who stated any system of socialized medicine threatens democracy. Socialized medicine would be expensive "for when the government provides a service, the cost of a round-trip ticket for the dollar from the taxpayer to the government back to the taxpayer must be paid"; Mrs. Ivy B. Priest, United States Treasurer, who urged support of the Administration, and Lewis K. Gough of California, National American Legion Commander, who urged continued free care for veterans with non-service ailments. He stated: "To turn the deserving veterans out of Veterans Administration facilities would only create a new social problem."

Dr. Alfred Blalock of Baltimore, Maryland, was awarded the Distinguished Service Award of the AMA (the sixteenth since 1938), for his outstanding work in vascular surgery, especially for his part in the development of the so-called "blue baby" operation.

The House of Delegates unanimously adopted a recommendation of its Reference Committee on Insurance and Medical Service that, except in cases involving tuberculosis or psychiatric or neurologic disorders, responsibility for the care of veterans with disabilities or diseases of non-service connected origin should be returned to the individual and to the local community.

In taking this action, the House reaffirmed and adopted the following recommendation originally presented at the Denver meeting last December by the Special Committee on Federal Medical Services:

"Your Committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and

(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service connected origin, who are unable to defray the expenses of necessary hospitalization.

Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

The reference committee report adopted by the House expressed complete accord with the present program of hospital and medical care for veterans with service-connected disabilities, and also included this statement:

"It is the belief of your committee that the medical profession must concern itself, not with the numbers of 'chiselers' in Veterans Administration hospitals nor with the efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of the country. A consideration of this problem must of course be predicated upon a concern for the health of the entire population and not just a particular segment."

Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. The House adopted a committee report which recommended no action on the eleven resolutions but which reaffirmed the supremacy of the AMA code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing.

"The Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession," the reference committee report said. "Any statement relating to ethical matters by other organizations within the general profession of medicine advances views of only a particular group and is without official sanction of the entire profession as rep-

resented by the American Medical Association."

Condemning generalized statements regarding the ethics of physicians, the report went on to say:

"Your reference committee believes that the harm done to the public and to the profession by the current articles which lower the confidence patients have in their doctors cannot be objectively evaluated. This highlights the fact that, when individuals or groups without official status in the American Medical Association utter or publish ill-considered statements, the result too often is that the confidence of the public in the medical profession is placed in jeopardy.

The reference committee believes that the members of the House of Delegates have demonstrated their devotion over the years to the principles of American democracy. This devotion includes the right of free speech. With this, the Committee agrees unqualifiedly.

Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these pitfalls without additional advice from this committee."

The report also urged that the American Medical Association continue to inform its members and the public of its stand on matters pertaining to abuses and evils in the practice of medicine.

Most controversial issue brought before the House at the New York meeting proved to be the question of immediate or deferred action on the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The House, after two hours of vigorous, spirited debate, adopted the majority report of the Reference Committee on Miscellaneous Business, thereby postponing action until the June 1954, meeting and allowing further study by the delegates and the state associations.

The recommendations of the Committee for the Study of Relations Between Osteopathy and Medicine were as follows:

"1. That the House of Delegates declare that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of "cultist" healing.

2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in the undergraduate and postgraduate education of doctors of osteopathy.

3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

4. That the Committee for the Study of Relations Between Osteopathy and Medicine or a similar committee be established as a continuing body."

A minority report of the reference committee urged approval and adoption of those recommendations at the New York meeting. The majority report, which ultimately won out, included the following recommendations by the Board of Trustees:

"Because of the length of the report and the controversial nature of the subject, the Board feels that the House should have adequate time for its study and that the state associations should have opportunity to express their opinions.

Therefore, it is recommended that the Committee be continued, but that action on the report be deferred until the June 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

1. Should modern osteopathy be classified as 'cultist' healing?

2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?"

Five resolutions came before the House with regard to the Essentials of an Approved Internship, which were adopted at the December 1952, meeting. The Reference Committee on Medical Education and Hospitals recommended a substitute resolution which was adopted by the House after considerable discussion. The action abolishes the rule whereby approval may be withdrawn from an internship program which for two consecutive years fails to obtain at least

two-thirds of its slated complement of interns. The resolution also calls for further study of the Essentials by a committee appointed by the Speaker of the House, at least half of whom are doctors in private practice not connected with medical schools or affiliated hospitals.

Member registrants from Arizona to June 4, were:

CHANDLER—Charles L. von Pohle, M.D.

PHOENIX—Joseph Bank, M.D., Joseph C. Ehrlich, M.D., Robert S. Flinn, M.D., Dudley J. Fournier, M.D., Joseph S. Lentz, M.D., Hilton J. McKeown, M.D., Bernard L. Melton, M.D., Howell S. Randolph, M.D., George K. Rogers, M.D.

TUCSON—Harriet S. Baritell, M.D., John K. Bennett, M.D., Benson Bloom, M.D., George L. Dixon, M.D., Clyde E. Flood, M.D., W. Ray Hewitt, M.D., Donald F. Hill, M.D., W. Paul Holbrook, M.D., Hugh H. McFadyne, M.D., Otis B. Miller, M.D., Raymond F. Oyler, M.D., Seymour I. Shapiro, M.D., Selig A. Shevin, M.D., Henry J. Stanford, M.D., Alden B. Thompson, M.D., Marguerite S. Williams, M.D., Elmer E. Yeoman, M.D.

YUMA—Robert E. Rider, M.D.

Respectfully submitted,
Robert Carpenter,
Executive Secretary

ARIZONA STATE BOARD OF MEDICAL EXAMINERS

Governor Howard Pyle appointed Orin J. Farness, M.D., of Tucson, Maurice R. Richter, M.D., of Phoenix, and Harry T. Southworth, M.D., of Prescott, members of the Arizona State Board of Medical Examiners, each for a term of three years, effective July 1, 1953. Carl H. Gans, M.D., of Morenci, and Abe I. Podolsky, M.D., of Yuma, incumbents, complete the membership. At a recent organizational meeting Dr. Podolsky was elected President; Dr. Southworth, First Vice President; Dr. Gans, Second Vice President and Dr. Richter, Secretary-Treasurer, for the ensuing fiscal year. Mr. Robert Carpenter was appointed Executive Secretary. The officers of the Board are presently located in the Security Building, Phoenix, Arizona.

Arizona Pharmaceutical Page

"CAVEAT EMPTOR"

ACCORDING TO LEGAL WRITINGS, THE RULE OF CAVEAT EMPTOR IS THAT "THE PURCHASER MUST BEWARE," AND SIGNIFIES IT IS THE DUTY OF THE BUYER TO PROTECT HIMSELF BY BEING ON HIS GUARD IN THE PURCHASE OF CHATTELS, ESPECIALLY BY MAKING AN EXAMINATION TO ASCERTAIN THE KIND AND QUALITY OF GOODS HE IS PURCHASING.

THE RULE OF CAVEAT EMPTOR, HOWEVER, HAS NO APPLICATION TO THE SALE OF DRUGS OR POISONS *AT WHOLESALE OR RETAIL*, BECAUSE THE *ORDINARY PURCHASER* OF A DRUG OR POISON CANNOT IDENTIFY, WITH PRECISION, THE ARTICLE CALLED FOR. THIS AMOUNTS TO SAYING THAT *THERE IS A WARRANTY BY THE PHARMACIST THAT THE DRUG DELIVERED IS THE ONE CALLED FOR BY THE CUSTOMER.*

NOW, IF YOU WILL NOTE THE USE OF THE WORD ORDINARY, WE WANT TO CALL YOUR ATTENTION TO A RECENT RULING, EMINATING FROM THE FEDERAL TRADE COMMISSION. IT FOLLOWS:

"ADVERTISING TO PHYSICIANS WAS CAREFULLY DISTINGUISHED FROM CONSUMER ADVERTISING IN FEDERAL TRADE COMMISSION EXAMINER KOLB'S INITIAL DECISION ON FTC'S COMPLAINT V. SPENCER BREAST SUPPORTS (NO. 5995). KOLB FOUND SPENCER'S ADVERTISEMENT CLAIMS MISLEADING, AS DISSEMINATED TO THE CONSUMING PUBLIC, BUT ADDED THAT *'NO ADVERTISEMENT OF RESPONDENT'S DEVICE IS DEEMED TO BE FALSE IF IT IS DISSEMINATED ONLY TO MEMBERS OF THE MEDICAL PROFESSION* AND CONTAINS NO FALSE REPRESENTATION OF A MATERIAL FACT.' THE FTC LAW IN DEFINING "FALSE ADVERTISEMENT" SPECIFICALLY EXEMPTS *DRUG* ADS SENT ONLY TO PHYSICIANS, IF THEY

(1) CONTAIN NO FALSE REPRESENTATIONS OF A MATERIAL FACT

(2) IF THEY INCLUDE QUANTATIVE FORMULAS.

NO CASES HAVE BEEN MADE AGAINST PURELY PROFESSIONAL DRUG ADVERTISING SINCE ENACTMENT OF THIS LAW IN 1938. THE FTC EXAMINER STATED THAT "SPENCER SUPPORTS HAVE NO THERAPEUTIC VALUE FOR DISEASES OR BODY CONDITIONS BEYOND POSSIBLE TEMPORARY BENEFITS IN SOME CASES, WHILE ACTUALLY BEING WORN. HOWEVER HE ACKNOWLEDGED THAT: "IN A SUBSTANTIAL NUMBER OF CASES, PHYSICIANS PRESCRIBE SPENCER SUPPORTS FOR THE BACK, BREASTS OR ABDOMEN AS AN ADJUNCT IN THE TREATMENT OR THE ALLEVIATION OF SYMPTOMS OF VARIOUS DISEASES OF THE BODY, OR AS A PREVENTIVE MEASURE, PARTICULARLY IN CASES OF FAULTY POSTURE." KOLB'S *PROPOSED ORDER WOULD SHARPLY CURB 22 ALLEGED THERAPEUTIC CLAIMS FOR THE DEVICES IN ADS TO THE "CONSUMING PUBLIC"*, AS DISTINGUISHED FROM THE MEDICAL PROFESSION. NO LIMITATION ON ADS TO PHYSICIANS WAS PROPOSED."

UNFORTUNATELY PHYSICIANS ARE PLACED IN A REALLY PRECARIOUS POSITION WHEN PURCHASING DRUGS. ANY FIRM MAY MAKE ANY CLAIM THEY PLEASE FOR THEIR PRODUCTS AND BE CLEARLY WITHIN THE RULING ABOVE. PHARMACISTS, ON THE OTHER HAND, ARE CHARGED WITH EXERCISING THE HIGHEST DEGREE OF CARE AND SKILL IN THE DISPENSING OF DRUGS AND, IN MANY COURT CASES, ARE HELD TO IMPLIEDLY WARRANT THE DRUGS THEY HANDLE TO CONFORM TO THE CLAIMS MADE FOR THEM.

A PHYSICIAN, IN ORDER TO BE SAFE FROM THE EXPLOITATION OF QUESTIONABLE MANUFACTURERS AND DISTRIBUTORS OF DRUGS, SHOULD CONSULT WITH HIS PHARMIST AND THUS ELIMINATE THE CAVEAT EMPTOR RULE IN HIS PURCHASES.

ANNOUNCEMENT
ARIZONA ASSOCIATION OF NURSING HOMES

IN BEHALF OF THE PUBLIC AND THE MEDICAL PROFESSION, THE "ARIZONA MEDICINE" TAKES THIS OPPORTUNITY OF WELCOMING THE ARIZONA ASSOCIATION OF NURSING HOMES INTO PUBLIC SERVICE. THIS ORGANIZATION WAS FORMED APRIL 13, 1953, IN PHOENIX. IT IS THE A.A.N.H.'S DESIRE TO CREATE AND MAINTAIN THE HIGEST POSSIBLE STANDARDS.

IN SERVING THE PUBLIC, AS AN ADJUNCT TO THE FIELD OF MEDICINE, IT WAS FELT THAT INDIVIDUAL OWNERS OF NURSING HOMES SHOULD COME TOGETHER IN ORDER TO ESTABLISH POLICIES AND STANDARDS WHICH WOULD BE A CREDIT TO ARIZONA.

THIS ORGANIZATION WILL WELCOME INTO ITS MEMBERSHIP ALL ARIZONA NURSING HOMES AND SIMILAR INSTITUTIONS.

A GOOD NURSING HOME IS A REAL ASSET TO OUR CIVILIZATION. DIRECT ALL CORRESPONDENCE TO:

EVELYN DODD, SECRETARY
ARIZONA ASSOCIATION OF NURSING HOMES
1608 EAST MEADOWBROOK AVENUE
PHOENIX, ARIZONA

Woman's AUXILIARY

Mrs. William Schoffman
Phoenix, Arizona

PRESIDENT'S REPORT ANNUAL MEETING 1953

Here, there and everywhere people are reaching toward ideals. It does not follow that these ideals are anything more than visionary in many instances. But, our ideals can be more realistic.

Only *first* we need to believe in our cause. Is the Medical Auxiliary a worthy venture? Is it right that we extend the aims of the Medical profession or cultivate friendliness and understanding among physician's families? Have we as an organization done anything to justify our existence? The answer to each question is yes and because it is realize and remember that the world is really depending upon us far more than we know.

We must have faith in our individual ability to help carry our own work forward. There is no assurance that every year will bring about startling innovations. However, the need remains to stabilize the good ideas of last year, by this year's effort and at least hold the line for next years workers. Even such a year is not without excitement.

Thirdly let us deserve an "E" for effort in the way we prove our belief in each other. Just as yeast works quietly in leavening bread, so an Arizona negro woman, a physician's wife, proved her belief in this auxiliary. She was among the very first women in the 1952-1953 season to become members in good standing. Though nothing was ever asked of her and nothing has since been offered, she did what she could and made a most significant point.

Last year we worked to gain a new President for these United States, the Medical group as diligently as any other. Was it because of his handsome appearance or the consideration he unfailingly shows his wife? In small degree yes, but in great degree we backed Mr. Eisenhower because of what his mind, his heart and his conscience stand for. Having voted him into office we are obliged and privileged to help him change the world, for the betterment of mankind. Such is his ideal.

Immediately new work is pointed out for this group in the months ahead. Our Legislative post assumes different proportions since we tried our hand at politics. We realize too that now we must stop talking about and actually begin to do something about Civil Defense. Ours is the home front, are we ready to protect it?

Actually we know what to do about most of our problems, personal and collective, but we don't use that knowledge. We could for instance, improve our personal finances by budgeting, but we don't budget; We could improve our health by dieting, but we don't diet; We could improve our careers by studying, but we don't study. Thinking is too hard. Information is piled high around us but we don't use it. There is no law against it however.

Your New President, Mrs. Enfield, is ready, willing and able to carry out the trust you have placed in her hands but she will be the first to acknowledge that the success of this organization, as any other, is in direct proportion to the thinking and active participation of the members and the potential members.

The reports of Officers and Committee Chairmen, on the varied program we sponsor, have been interesting.

Tomorrow the Presidents of our Seven organized counties will give contrasting and indivi-

dual methods of handling this program as well as local needs.

You will hear what money makers are Yavapai members; You will find what spenders Graham County harbors and just how much the mean 'no socialized medicine'. Though discouraged and with just cause – since the stork seems to have taken permanent residence in Gila County –hear what belief in each other, a little encouragement from state officers did for this group. You won't hear it from their report but, you should know that Pinal County, our baby, is also our most independent county. They decided to do nothing this past Fall. Then with thanks to no one but themselves they had a change of heart. Their's is a creditable record in public relations.

As women we understand that participation in the Medical Auxiliary isn't the aim of life. Still we can't be indifferent to the fact that through this organization we can come of age as good American citizens and that is certainly a great big part of life.

Americans originally built a nation around an ideal. Let us think big and build this auxiliary around the ideal of Americanism.

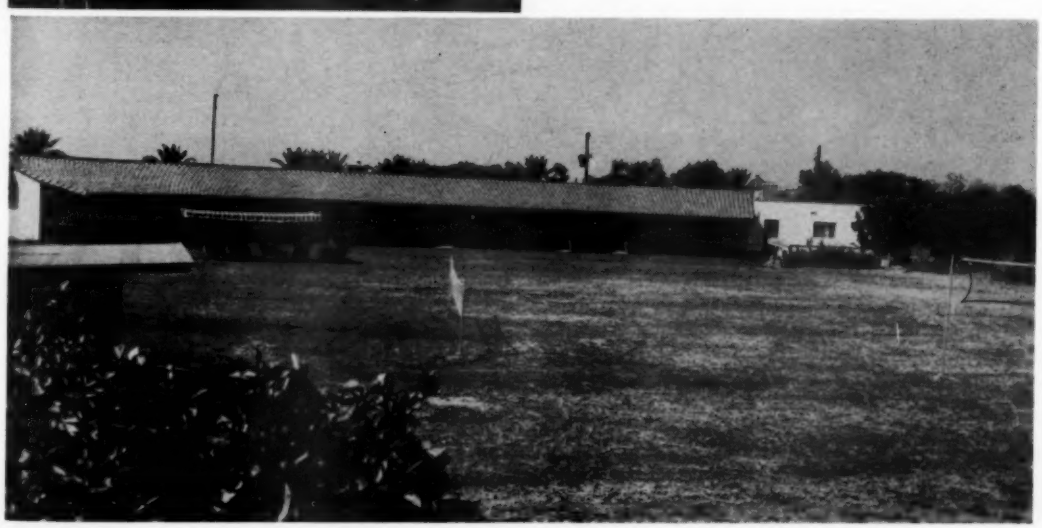
None of us ever doubted this day of reckoning would arrive. What I can't understand is how it got here in such a hurry. You have given me two of the best years of my life. Years filled with new experiences, now friendships and a wider outlook. I am deeply conscious of how little I had to offer compared with the bounty received but from the bottom of my heart, please accept the appreciation I feel for your loyalty, your remarkable hospitality, your generous understanding and patience.

God love you and keep you through the coming year.

Respectfully submitted,
Ruth E. Schoffman
Phoenix, Arizona

LABORATORIES

SANATORIUM DIRECTORY



SANATORIUM DIRECTORY—(Cont'd)

SANATORIUM DIRECTORY

AMBULANCE DIRECTORY

MEDICAL SUPPLY DIRECTORY

Telephone Answering Message Service

HOSPITAL DIRECTORY

DRUGGISTS' DIRECTORY

DRUGGISTS' DIRECTORY

DRUGGIST DIRECTORY

MINERAL WELLS DIRECTORY

X-RAY COMPANY

DOCTOR'S DIRECTORY

MEDICAL BOOKS

NURSES' DIRECTORY

PHYSICIANS' DIRECTORY

NEUROLOGY and PSYCHIATRY

PROCTOLOGY

Plastic and Reconstructive Surgery

PHYSICIANS' DIRECTORY

UROLOGY

ROBERT H. CUMMINGS, M.D.

Diplomate of the
American Board of Urology

Park Central Medical Bldg.
Phone CR 4-4912
550 W. Thomas Road – 207 Patio A
Phoenix, Arizona

W. G. SHULTZ, M.D., F. A. C. S.

Diplomate of The American
Board of Urology

E. R. UPDEGRAFF, M.D.

1010 N. Country Club Road
Telephone 5-2609 Tucson, Arizona

PAUL L. SINGER, M.D., F. A. C. S.

Certified American Board of
UROLOGY

1313 N. Second Street Phone ALpine 3-1739
PHOENIX, ARIZONA

DONALD B. LEWIS, M.D.

UROLOGY
Certified by the American Board of Urology

123 So. Stone Ave. Phone 2-7081
Tucson, Arizona

MALIGNANT DISEASE

JAMES M. OVENS, M. D.
F.A.C.S. F.I.C.S.

Diplomate American Board of Surgery
Cancer and Allied Diseases
608 Professional Bldg. Phone ALpine 4-1973
Phoenix, Arizona

ALLERGY

E. A. GATTERDAM, M.D.

ALLERGY
15 E. Monroe St., Professional Bldg.
Office Hours: 11 A. M. to 5 P. M.
Phoenix, Arizona

CLINIC

NELSON CLINIC
D. E. NELSON, M.D.
A. H. ERICKSON, M.D.

503 Fifth Avenue
SAFFORD, ARIZONA

SUN VALLEY CLINIC

34 North Macdonald
MESA, ARIZONA

ANESTHESIOLOGY

LOUISE BEWERSDORF, M.D.
HERMAN BEWERSDORF, M.D.

ANESTHESIOLOGY
Park Central Medical Bldg.
Phone CR 4-5674
550 W. Thomas Road – 24 R
Phoenix, Arizona

HOSPITAL

H. B. LEHMBERG, M.D.
J. T. O'NEIL, M.D.

Casa Grande Clinic Phone 4495
Casa Grande, Arizona

PHYSICIANS' DIRECTORY

INTERNAL MEDICINE

ROBERT S. FLINN, M.D.
INTERNAL MEDICINE
CARDIOLOGY and ELECTROCARDIOGRAPHY
Park Central Medical Bldg.
Phone AM 6-8485
550 W. Thomas Road – 217 Patio B
Phoenix, Arizona

JESSE D. HAMER, M.D.
F. A. C. P.
INTERNAL MEDICINE
CARDIOLOGY
Suit 910 Phoenix
15 E. Monroe St. Arizona

FRANK J. MILLOY, M.D.
F. A. C. P.
INTERNAL MEDICINE
611 Professional Building
Phone ALpine 4-2171
Phoenix, Arizona

DAVID M. MARCUS, M.D.
INTERNAL MEDICINE
1850 N. Laurel Avenue – Phone ALpine 4-7970
Phoenix, Arizona

ROBERT E. RIDER, M.D.
INTERNAL MEDICINE
ELECTROCARDIOGRAPHY
Del Sol Hotel Bldg. Phone 3-3721
Yuma, Arizona

JOSEPH BANK, M.D.
Diplomate of
American Board of Internal Medicine
American Board of Gastroenterology
GASTROENTEROLOGY, GASTROSCOPY
800 North First Avenue Phone: ALpine 4-7245
PHOENIX, ARIZONA

OBSTETRICS and GYNECOLOGY

HARRY J. FELCH, M.D.
Physician and Surgeon

Residence	Office
325 W. Granada	703 Professional Bldg.
Phoenix, Arizona	15 E. Monroe Street
Residence ALpine 3-1151	Office ALpine 3-1151

CHILDREN'S DISEASES

WM. F. SCHOFFMAN, M.D.
CECILIA H. SHEMBAB, M.D.
JOHN R. KEEFREY, M.D.
DOCTORS BUILDING
316 W. McDowell Rd. – Telephone ALpine 4-7287
Phoenix, Arizona

DERMATOLOGY

GEORGE K. ROGERS, M.D.
DERMATOLOGY
Diplomate of American Board of
Dermatology and Syphilology
Phone ALpine 3-5264
105 W. McDowell Road Phoenix, Arizona

PHYSICIANS' DIRECTORY

SURGERY

ORTHOPEDIC SURGERY